DOCTORAL PORTFOLIO IN

COUNSELLING PSYCHOLOGY

An exploration of Counselling Psychologists' experiences of subjective and objective countertransference and how this impacts the therapeutic process

By

Drusilla Ann Joseph

A portfolio submitted to the University of Wolverhampton

for the Practitioner Doctorate: Counselling Psychology

Award: D.Couns.Psych

July 2015

Abstract

This study seeks to qualitatively explore and understand counselling psychologists experience of subjective and objective countertransference within individual therapy and how this affects the counselling process. Historically the available literature suggests that the development of countertransference has been dominated through theoretical papers rather than empirical research. The complex nature of countertransference amongst practitioners can often cause controversy and debate when it is further broken down into subjective and objective factors. Not only does this impact the therapist, the client and the working alliance, but also the larger systems operating around these variables. This study provides a rich and detailed examination of subjective and objective countertransference through the methodology of Interpretative Phenomenological Analysis (IPA). Six counselling psychologists participated in a face-to-face semi-structured interview revealing countertransference in three parts; subjective, objective and contributory factors giving rise to seven superordinate themes. '**Subjective' Super-ordinate** revealed 'Professional, Personal and Reactors'. **'Objective' Super-ordinate** found 'Clients life outside the analysis' and '**Contributing Factors to Countertransference' Super-ordinate** encapsulated 'Service restrictions, Therapeutic Relationship and Training'. These findings support several conceptual and theoretical published papers, however this empirical investigation adds to the literature through further informing clinical practice. It does so by separating parts of countertransference, digging deeper into those parts in an isolated way showing the affective processes, techniques, the interplay of evoked feelings to better manage countertransference in the moment of experiencing it and overall how this impacts the therapeutic relationship. Future research could consider exploring how counselling psychologists in the UK focus their attention on distinctive parts of subjective and objective countertransference (subjective countertransference thoughts, subjective countertransference feelings and subjective countertransference behaviours, as well as objective countertransference thoughts, feelings and behaviours separately), further research would also benefit from qualitative investigations of subjective and objective reactions when working with certain populations, for example, diagnosis/symptom-specific individuals, certain demographics and/or investigating couples or family systemic groups

and whether this has any impact on the working alliance, therapeutic technique, intervention and outcome. Potential clinical implementation include counselling psychologists becoming better positioned to recognise when subjective and objective countertransference is occurring, what to do with it through the application of techniques and how to maintain a ‘good enough’ working alliance.

Contents

ACKNOWLEDGMENTS

Firstly, I would like to thank both Garrett Kennedy and Victoria Galbraith for taking a leap of faith in accepting me onto this life-changing course. I am sincerely grateful for the endless support and encouragement you both have given. Thank you.

To the teaching staff at the University of Wolverhampton (especially Abigail Taiwo for supervisory support) and the ladies who have endured this journey with me I am ever so humbled to have shared this phenomenal experience with you.

My gratitude is also extended to all my supervisors throughout my years at placement especially Dr Paul Morland who truly accepted me for me, encouraged finding my own therapeutic pathway and gave me the gift of exercising the humanistic mantra of *just being*.

Finally to everyone who took part in this study, thank you, without your patience, experiences, open and honest responses my research would never have shaped and formed the way it has done; so I am forever in gratitude.

DEDICATIONS

I would like to dedicate this portfolio to both my Parents especially my Mother. Victoria R. Cosbert who epitomises the word *Mother*; has the backbone of a thousand warriors and a heart of gold. This woman has single handedly inspired, pushed through and remained my constant support, her endless energy, time, love, patience and encouragement has helped me reach an impossible dream and because of you it has become a possibility. Thank you for the many sacrifices and for that I am forever grateful.

Thank you to Wilfred Hoenkirk for his time, patience, energy and above all the endless help offered throughout this journey.

It goes without saying that my Father is a compassionate man, his love from a distance still teaches me many things, his words of wisdom comforts me daily and I am blessed to have a kind heart and soulful man to call Dad.

I must also acknowledge both my Grandparents my late Grandfather Dr. Winston F. Cosbert, a man of many extraordinary talents, whose mind was phenomenal and who believed I could pursue this Doctoral process without an ounce of doubt. My only wish is that you were still alive to see this remarkable accomplishment.

Lastly my Grandmother Hazel P. Cosbert. What an inspirational soul, your endless prayers, faith and hope has indeed gotten me this far. Thank you.

WORD COUNT SUMMARY

Section	Page no.	Word Count
Preface		2,139
The Academic Dossier		
Psychodynamic Approach PS5010 Therapeutic Issues & Ethics PS5001		3,005 2,986
Research Dossier		
Literature Review Empirical Research Discussion Critical Appraisal		6,251 11,421 2, 341 2,399
TOTAL		**30, 542**

For ethical, moral and confidentiality purposes all clients and participants referred to throughout this portfolio have been anonymised for protection and safe guarding by removing identifiable information.

Preface

An Introduction to this Doctoral Portfolio

This portfolio is a submission for the degree of Practitioner Doctorate in Counselling Psychology at the University of Wolverhampton. This Doctorate is the result of a two-part Dossier undertaken through the University consisting of Academic and Research completed works. Within these two areas one considers each to have important offerings that make up this Doctoral portfolio and will highlight the reasons as to why throughout this preface. Additionally, there will be a Confidential Attachment submitted separately providing (where appropriate) significant pieces for reference such as raw data and transcripts.

Firstly, the Academic Dossier consists of two essays that exhibit topic areas' which relate to one's placement practice as a trainee Counselling Psychologist. Both written in the second year of the Doctorate Course, one felt a personal transitional shift in becoming less theoretical and more practical, thus the modules that keenly represented this came at exploring the *Psychodynamic Approach* and the *Therapeutic Issues & Ethics* framework.

Lastly, the Research Dossier is a composition of original work displaying captured research findings in an Interpretative Phenomenological Analysis (IPA) manner resulting in contributory acknowledgements to the chosen area, of which, is countertransference and the world of Counselling Psychologists. Here a review of the literature and an empirical investigation were undertaken and demonstrated alongside a critical appraisal of one's development as a researcher and practitioner.

In order to be the best possible practitioner, practiced based evidences were defining moments in realising my potential as a trainee. Referring back to the Academic Dossier as mentioned above, the first essay in this portfolio is entitled '*Evaluate the Psychodynamic model of Counselling Psychology in relation to your work with a specific Client.'* Here taking the scope of using theory and demonstrating it within practice was a slow but useful tool of integration as a Trainee Counselling Psychologist. It highlighted the extra capabilities that one possessed (and did not know until this module emerged) that one could refer to such an orientation as and when needed for specific clients. The

psychodynamic module therefore opened up a new contextual arena, in which, it fused all parts of the human psyche together, (the idea of a collective unconscious mind, bringing forth to consciousness) were both fascinating and intriguing elements to take into account and develop from. It was therefore my responsibility to use this approach appropriately and wisely within practice. It also highlighted and introduced countertransference in a conceptual format manifesting its' origins and case study approaches to help not only my research but also my practice. This was not only exciting but became apparent that this contextual skill had its place within my toolbox of therapeutic interventions.

I chose to implement this specific essay because it shows a sign of personal growth yet demonstrating the care, meticulous attention and intricate holdings of a therapeutic relationship. It remarkably portrays the passion this type of work brings out within me and in a narrative form captures insightfully a different way of creatively working. The utmost marksmanship to this career path is that one needs to be rooted as a reflective/reflexive practitioner in order to carry out any type of therapeutic work, which significantly this essay powerfully displays in one's opinion. This was a true turning point in establishing this method and a great learning curve within practice.

Overall, bridging theory to practice is never an easy concept especially with such an intervention that is intangible, however reading around the subject and doing justice to the scholastic contributions such as Freud (1914), Melanie Klein (1882-1960), Carl Jung (1875-1961) and Donald Winnicott (1896-1971), were essentially a part of the process that one needed to tackle for future endeavors.

Additionally, I have chosen to insert '*Therapeutic Issues & Ethics'* within the body of this portfolio because it really shows the *stuck* feelings therapists often experience during the therapeutic process. For me especially being a Trainee Counselling Psychologist when faced with perplexed ethical decisions and not knowing what to do next and often feeling alone in the process when in the therapeutic space; leaning on the ethical frameworks such as the British Psychological Society and the Health & Care Professions Council (HCPC) were reassuring affirmations that one needed. This essay encapsulates all angles of decision making when facing with an ethical dilemma. Not only is one thinking of the

clients' wellbeing and yourself, but it extends to the service and the service users family. Decisions are never an easy task to adhere with but its' also a responsibility that comes with this body of work and in turn reflects on not just you as a practitioner but the registered bodies (HCPC, 2012).

This was the first time on this course that we (trainees) as a group attempted to look at our profession in terms of legality. It was an eye opening experience simply because it brought about the nerve wracking part that exists for all of us. The idea that one could be sued, that if procedures and protocols are not followed or upheld licenses may be revoked or suspended, that the care and practice of this profession comes with a warning label and if misused maybe the end to the profession as a whole. This module thus sparked topical discussions and scenarios of moral, ethical decision making dexterities and pushed our therapeutic boundaries to new heights.

With this in mind, during this period of writing the essay it marked a significant turning point both personally and professionally. Personally one struggled with the concept of getting the process of delivering therapy 'right' within my clients session and one really questioned at that pivotal time, what that meant for me, why it was so important and what really were the telling points to getting the process right. Being extra cautious due to the nature of this particular module was apparent to say the least. Therefore one struggled with this quite a bit and battled with parts of myself that were not allowing me to *just be* and trust ones own inner compass. The idea of over thinking, not being *good enough* and questioning my skills were all a part of this transitional shift. This was the first time one really embarked on this negative route/ journey and was not quite sure of the reasons. Perhaps the realisation that my decisions held a lot of power and weight (legally) might have brought about fear or doubt, as it seemed like extra pressure.

Contributory factors that made this procedure even more so challenging was that this was the very first time one worked with the diagnosis of Severe Depression with an Adult and thus became self-critical of trying to make this progressive process an educational, beneficial and overall translatable one. Conversely, doing this *essay* (upon introspective

reflection) one began to utilize all my training and found that this lonesome road was in fact a blessing in disguise. As writing in my reflective journal became a useful and exploratory way of working as it was thought provoking, it pushed and helped confront parts of ones' self that sometimes became challenging to face yet rewarding to understand. Accepting parts of the self and being committed to the idea of that acceptance was a massive learning curve which one quickly developed. This helped as one could really analyse the client, the situation, the relationship, the in-betweeness, the engagement, the language and the overall tools/skills that one possessed but was not aware of within the moment of delivering therapy. It was an eye opening experience to say the least.

Overall, on a personal note, the concept of legality took a while to get adjusted to, but it became one of the best therapeutic process', therapeutic relationship, formulated intervention and collaborative work one ever ensued. The pace, congruence and honesty helped build the foundations of this engagement and it was one of those moments that made every part of me realise that as a developing psychologist one has the necessary instruments to make *good* change happen with sound ethical/moral judgments made best for the client and practice.

Professionally one thing that ultimately placed a lot of worries at ease and drew them narrowly into focus was the Hawkins & Shohet, (2012) Supervision in the Helping Professions book. Here it discuss' an approach called the *seven eye model of supervision,* this placed great emphasis on my second year supervisor as it widely offered a systemic overview of the dynamical relationship being played out in a dual processing way for example not only looking at the supervisory relationship, but the supervisor, supervisee and client relationship. This thus inspired me to naturally develop an inner supervisor and gave another dimension to my professional skills in writing this report.

As part of my Research Dossier I chose the topic area countertransference and decided to stick with this subject due to the startling effects it caused during practice on first year placement. Having first hand experience as a trainee Counselling Psychologist countertransference brought forth a battle of unresolved conflicts toying with my internal world, dialogue, perceptions and fears subconsciously arising and counteracting with my

many levels of selves particularly the therapeutic self, the humanistic self and the childhood self. This indeed was a steep learning curve, which inevitably became my basis to build on for my future research thesis.

One remembers the challenging nature a client brought to session both inwardly bruising my inner being, its core, pushing all the right buttons that left me with debris of confusion. It was remarkable how one was always so outwardly being reflective and it took one moment for someone else to inwardly scar parts of me not quite knowing what to do next and having to fuse this disjointed mess back together to be with my client once again. This client exercised a part of me that was somehow hidden for a substantial amount of time, but some how became exposed due to the directive coercing of his words being said.

One felt strange internally as my senses were (what it felt like), microscopically heightened, becoming more aware of what I was thinking, feeling and behaving. To regain control of these parts of me as well as persistently re-focus on my clients needs (as one was not present and had vanished for a mere few moments) made me question what had just taken place. Perhaps the nature of getting lost in this cognitive behavioural loop whilst experiencing transferred elements that one had no control over made me question this snapshot in time.

This got me wondering about the thinking, feeling and behavioural aspects of countertransference as well as the nature to manage it in the moment of experiencing it. For weeks this '*thing*' aggravated me, whatever he had given to me (as translucent as it was) impacted me tremendously. One thus began to read around countertransference with its many plausible definitions and whittled my search down to finding relevant research, which remotely peeked into the journey one had momentarily experienced both raising the concepts of 'subjective' and 'objective' countertransference. With this curiosity the research journey began.

My literature review however has been broken down into three parts (an introduction to countertransference, subjective and objective countertransference) helping to shed light on what countertransference is regarding issues of definition/theory, the effectiveness of methodology employed through qualitative and quantitative studies to aid this very

intangible concept to a tangible one.

The Empirical research contains the Methodology of IPA breaking down the aspects of why this particular approach was used for this study and gives an overall insight into the background of this developing method. The results are intricately detailed complimenting existing research, opening and acknowledging new points of reference, somewhat also minimising current gaps; all to build on directional ways researchers may want to pursue for further future exploration when it comes to countertransference.

My findings therefore underlines that countertransference is a source of insight into how it has an overall influence upon our work as therapists and psychologists. There are many elements we need to take into consideration that contribute to the process, the moment and the aftermath of managing countertransference within practice.

This portfolio highlights my shaped journey so far, showcasing intricate parts of who I am and who I have become on this road of self-discovery. It has been an ample part of growth ensued through my training, placement and the many clients that I have helped along the way. As I reflect back on the pit stops so far and the journey that lays ahead I have learnt a great deal of patience and compassion both for myself and others. My mission now is to give back to those that need it the most and be as equipped as I need to be in order to empower and promote self-management for any diagnosis that walks through the therapeutic doors into the therapeutic space.

References

HCPC, (2012); Health and Care Professions Council. Standards of proficiency-practitioner psychologists

Hawkins, P & Shoet, R (2012) Supervision in the Helping Professions. Open university press

ACADEMIC

DOSSIER

Psychodynamic Approach PS5010

'Evaluate the Psychodynamic model of Counselling Psychology in relation to your work with a specific client.'

May 2013

(Word count: 3,005)

Module Leader: James Porter

Drusilla Joseph - Counselling Psychologist in Training
Student number: 1205937
D.Joseph@wlv.ac.uk

Introduction:

"Each of us shapes his relationships according to the patterns internalized from his earliest significant relationships" (Mitchell & Black, 1995; p 121)

Therefore the purpose of this essay is to explore and assess the psychodynamic model in relation to the therapist's clinical work as a trainee Counselling Psychologist. The essay will further capture significant parts of the developing therapeutic alliance with a specific client, whilst demonstrating and exercising the beginnings of becoming aware of the theoretical framework, with its' slow integration into practice whilst evaluating significant inter-relational dynamics in depth.

Firstly, the therapist would like to acknowledge that the movement of Psychodynamic work was birthed from the historical context of Sigmund Freuds' (1914) Psychoanalytic perspective; by which human behavior were readily associated with the unconscious mind (the id, the ego and the superego), its' repressive/unresolved conflicts of emotions and the pinnacle that psychosexual stages had on complimenting the developmental cycle. This classic theorist spoke of this domain as being a *science*, which with know tangible evidence placed this body of work under much scrutiny. With such an idea, we can see how very difficult it would be to input this method of theory within clinical practice. Nonetheless, scholars such as Gill (1983) acknowledges this idea and calls psychoanalysis a very unique *hermeneutic science* as it obeys all aspects of science yet deals with the idea of human meaning. Additionally Dreher (2003) concurs that psychoanalytic concepts are *intrinsically hermeneutic* that elasticity is placed on a central core with room to change, expand and re-shape indefinitely; whilst many others such as Wallerstein (2009) proposes that Freud took this concept as *a priori* that in fact psychoanalysis "is an evolutionary-based, biological science, a science of the mind within the biological body…" (p 109).

Unfortunately, Freuds' argument relies too heavily on the underpinnings of sexual development as the main focus, hence the likes of Carl Jung (1875-1961) whose predecessor (Freud; who vastly influenced him) disagreed with such a concept and ensued back to the frame of the unconscious mind. Carl Jung (1875-1961) therefore adopted the idea of the *collective unconscious* focusing more on the commonality that human beings

share and this commonality directed new theoretical works such as Melanie Klein (1882-1960) and Donald Winnicott (1896-1971). Their focal point thus explored the significant early relationships that impact our central core; who we are shaped to become and as a result has heavily influenced current day practitioners such as Counselling Psychologists and their integrative work. With this wide application of historical, epistemological and even philosophical markings of the evolution of the psychoanalytic frame it is clear that "…current psychodynamic theory has moved away from the Freudian vision of development…and instead [looks at] the role parenting plays in the formation of a sense of self and others" (Burton & Davey, 2006, citied in Larsson 2012; p10).

Lastly, one of the political positioning that one has noticed influencing modern practices of psychodynamic principles, very much lays with the organisational settings in which they are performed. This in turn has massive implications on how affective the role of the Counselling Psychologist can be in relation to their specific work being pursued with clients. More specifically environments such as the National Health Service with the initiative of Improving Access to Psychological Therapies (IAPT) has a protocol which has an economic time restrained roll in roll out system and may not have the scope for deeper exploration in a psychodynamic way; whereas other institutions such as the Child and Adult Mental Health Service (CAMHS) may do. These contributing factors all influence the way Counselling Psychologists' respond to the theory base evidence or the evidence base theory.

Reflective Account: Case Study with a specific client

"If it wasn't for *her* I wouldn't be here." Stated this seven year old client called Poppy (name changed to ensure anonymity) who upon meeting for the third time within the therapeutic space at CAMHS had opened up about the significance of her past and its' clearly repetitive hold on her present state. This very bright, aware and quite articulate young girl readily had what it seemed like heroic fight with sprinkles of regressive anger and resentment in her very being. The trappings of her past came at physical, verbal and emotional abuse being placed upon her by her biological Mother. Larsson (2012) admits "…a child becomes an independent subject only if they recognise the autonomy and

separateness of their caregiver; this is known as intersubjectivity" (p 10). It was clear by those words alone a greater story was being told. That Poppy had distanced herself from the physical confinement of her biological Mother, yet emotionally through this model of free association her defense mechanism of repressive material was coming through. The Therapist did question whether this verbatim of material originated from the client or a parental influence due to the aggravated undertone of the language spoken. Still, in this moment it was Poppy exercising her own truth in her own inner world, which the Therapist was beginning to see a glimpse of.

Upon reflection, the idea of the *bad breast* represented by Melanie Klein (1882-1960) cited in Mitchell & Black (1995) seemed to perfectly describe the tumultuous interrelationship that Poppy was displaying. The notion of love, hate, anxieties, defenses, and introjection being applied bio-psycho-socially meant there was an imprint left by the Mother and projected onto the Therapist in what it seemed like a mirroring fashion. It was clear that this imprint was a debris of *imaginal splitting* leading to *self-splitting* (Cashdan, 1988) therefore often having Poppy wonder whether she was *all bad*; thus in a self-destructive manner acted in such a way outside the therapeutic space. As Jacobs (1999) points out "Psychodynamic counseling involves much more than talking about difficulties-it also means trying to face them in the 'here and now' of the therapeutic relationship which often involves transference of implications"(p26). Therefore witnessing this moment her words penetrated deeply within the therapist and it was evident that Poppy's transference (Cartwright, 2011) was one of hurt, anger, confusion and disappointment of the unresponsive care of her central attachment figure (Bowlby, 1988), this sense of abandonment and rejection seemed as though it was one major relational aspect that contributed to shaping her present psychological problems (Daniel, 2006).

Taking a step back (observationally) the therapist watched Poppy draw a picture of her family structure and noticed her body language after making that statement had shifted to annoyance. Her facial expression dropped as it became red, flustered and in that moment one "…was allowing myself to be used by [Poppy as] I served as a mother in my emotional availability " (Larson, 2012; p 14). The Therapist was purposely silent to allow the client to acknowledge her own emotional pain. Whether Poppy was annoyed at

the Therapist for allowing this to happen, it was evident that she was using the Therapist as an object and relationally getting her pent up suppressed feelings out, as well as her unconscious slowly surfacing to her conscious, which alongside that the therapist experienced countertransference (Jones, 2004; Cartwright, 2011).

The countertransference stemmed at the Therapist wanting to emotionally comfort her. It felt like the presenting past of her parental relationship whether it was projection or projection identification from biological mother (more specifically manipulation of power) to child had seeped into their relationship, whilst a bit of projection and displacement was now being transferred onto and into the therapist. This interpretation of her unfilled hopes, needs and longings to be cared for were wished fulfilled elements wanting to be granted by the client but the position her Mother had left her in was a state the client would have to fix or mend on her own. This negative transference (the unresolved rage towards her mother) instinctually made the therapist feel she needed to continue rescuing and protecting her in a very Person-Centred manner (Mearns & Thorne, 2007).

The Therapist thought in a psychodynamic fashion that this associated behavior would continue if it were not resolved. Therefore, she took into account the care of intervening by bringing the negative transference as well as the countertransference (Racker, 1957; Hayes, 2006; Cartwright, 2011; Holmqvist & Armelius; 1996) to the clients' awareness. Upon reflection introspectively in that moment the therapist was hesitant and wanted to hold back due to the readiness of the client, the session stage of therapy, the wanting to formulate the therapeutic frame further and was perhaps frightened of the clients' reaction to her interpretation or observation. Yet being with Poppy, walking with her side by side on her journey with running commentary gave clarity to the situation as "…sensing a space in which a possible 'opening up of the unconscious' [was] happening" (Barahona, 2004; p 276). Thus being brave in reflecting these feelings and interpretation back to her in a gentle, empathetic, and congruent way (remembering my humanistic base); made Poppy in someway become antagonized by her new found awareness, which she then blurted out "I just want to get on with my life." This then indicated that Poppy was perpetually on the defense (avoiding) as Jacobs (1985) points out

"…beneath the anger there may also be deep sadness, emptiness or profound sense of helplessness and weakness, all of which are defended against by rage" (p 50). Poppy's inner conflict was that her Mother was a barrier to her progressing or moving forward, which in hindsight one can now understand why this little girl would constantly 'turn against the self' outside the therapy room and would often imitate her biological Mothers actions e.g. calling herself her Mothers name and endure in trichotillomania. This idea that her biological Mother has rejected/abused her therefore she must also reject/abuse herself has undoubtedly led to pent up rage. The significance of the past and its constant repetition in the present makes the interrelationship of her external and internal worlds very complex.

With Poppy's previous comment, she thus became silent. Through the process of her artwork, she continued to draw her family structure where the therapist noticed that she had coloured her biological fathers' face purple. Witnessing this the Therapist brought this to her attention and asked the client what this meant (as know other family members were coloured in). Poppy replied that she just liked the colour, but As Jacobs (1999) would say "the psychodynamic approach tends to look deeper, to see if there is any *other* reason, which is disguised by the more obvious excuse" (p 91). The therapists' interpretation in this moment (through process of elimination) drew on the fact that it was a representation of something far deeper. Rather an interpretation of the kind of relationship Poppy has with her father and the esteem she sees him in. Purple for the Therapist symbolically signified a plethora of elements such as a mixture of good and bad traits of a father, rewards and punishments, or someone perhaps bruised and hurt trying to be attentive, but perhaps emotionally also unavailable. That there was a lot of buried and perhaps significant emotional chaos which he was also projecting/displacing onto Poppy directly or indirectly. This central figure definitely was important to Poppy's' internal world and being this of an interpretation the Therapist did not highlight such a powerful observation, but in the end took it to supervision. The way in which her family also was presented in a cohesive, militant way (lined up in a row); what seemed like a stable environment later down the line through bringing her unconscious to the forefront and making her aware of what she was portraying; the therapist realised that in fact there was a need for a stable family unit; more specifically a warm, loving, caring, nurturing environment which what it seemed like

needed routine with consistent emotional support. This was a great start to a better understanding of Poppy, where she saw herself in her family structure, her immediate dynamical relationships, her sense of *self* being influenced, shaped and molded by others. As Cashdan (1988) would conclude "…the inner world of the child [is] a world of human relationships" (p 5) **(See Appendix A)**

Boundaries (the therapeutic frame)

Although not working in a purist fashion when it comes to integrating theory to practice of the Psychodynamic model. The function of the therapists' maintenance of boundaries was of an important one (Piovano, 2008; Jacobs; 1999) when it came to working with Poppy. Psychodynamic principles will clearly point out by ensuing a frame of time, space, setting, establishment of roles with all parties involved and rules of confidentiality (Gutheil & Gabbard, 1993) needs to be addressed and sought after for the beginnings of building a therapeutic relationship. Therefore the contained boundaries/frame that were consistent with Poppy were having the same time, day, place, session length, and one on one work alone with Poppy. On one very significant day upon arriving to our sixth session, however, the therapist met Poppy in the waiting room, as her name was called for her appointment, she insisted that she bring her Father into her session " I want Daddy to come in with me " she demanded. As Jacobs (1999) would argue "…the counsellor who uses a psychodynamic technique prefers the client to speak of whatever comes to mind, to 'free associate,' [that this encourages] the client's speaking of anything that is uppermost in her or his mind "(p 33). Nonetheless the therapist was taken aback by this free association as it suggested or perhaps hinted that the therapeutic relationship dynamic had changed somehow, as Poppy had never insisted, demanded or cared for having her Father be present within her sessions. She pulled her Fathers arm indicating that he proceeds with her, yet something was not quite right between Poppy and the therapist, one thought of her transference; those that had let her down in the past and most importantly those letting her down in the present. The Therapist was thus experiencing her transference and acknowledged this as rejection. That her attachment style being an insecure-ambivalent one (Bowlby, 1988; Jacobs; 1985), knowing that her biological Mother had rejected and punished her previously, that now she was doing the same to the

therapist in a persecutory way. The feeling was present and one wondered if she felt that too. As Schermer (2011) points out "interpretation informs all human exchanges not only in words, but also intuitively and nonverbally, in body language and gestures. Indeed, humans are always interpreting and giving meaning to experience at every moment " (p 818). With clear observation as we walked down the corridor, this feeling became stronger as Poppys' body language became avoidant and very dismissive towards the Therapist. As by considerate effort she was trying to make the Therapist jealous by giving her emotional attention to her father and creating distance between the Therapist and herself. The Therapist further "interpreted that a part of [Poppy] needed to ignore [the therapist] so that she could feel in control and self-assured" (Ayala, 2005; p39). But Conversely, with autonomy the Therapist made a professional and informed judgment with decision making (BPS, 2009) to proceed with a very directive stance ensuing that the space and room not be contaminated by the parental figure as this would be damaging for the client whilst breaking confidentiality, safety and welfare needs if he enters.

Upon reflection this very idea of the Oedipus complex was playing out tremendously. Poppy being in the latency stage (Freud, 1914) of her development and has internalized her world as 'Daddy's little girl' made it difficult for the Therapist to continue to formulise the growth of the therapeutic alliance in that moment, as Coatsworth (2001) puts it best by stating "engaging and retaining clients in treatment are two of the most critical challenges that confront clinicians…" (p 313) Nonetheless further improvement with this clinical work would be to have her biological Father seek parental intervention with another clinician juxtaposed with his daughter, as what was thus left between Poppy and the Therapist, was this immediate feeling of causing her pain and perhaps failing her as a confidant, or *good enough* parental figure. As posed by Winnicott citied in Mitchell & Black (1995), " if the child expresses spontaneous desire and the desire is not fulfilled, [she] feels ignored or misread and impingement occurs" (p 129). Her perception was thus tainted of the Therapist as she withheld information and conversation, detached herself and became unresponsive. It felt from the client that the Therapist had "…appeared as an other, or rather as a symbolic *O*ther" (Barahona, 2004; p 276) in that moment to cope with her psychological and emotional pain. This gave the Therapist the opportunity to reflect back

to Poppy all that had just happened bringing in the idea once again about confidentiality and boundaries. As Cashdan, (1973) citied in Cashdan (1988) would argue, "…highlighting the emotional message…the therapist establishes an empathetic base for emotional linking" (p 16).

Evaluation

In conclusion Psychodynamic principles has taught the Therapist the undercurrent of going beyond the surface level of any client and how to apply all the theoretical and historical contexts of such an application in an integrative manner. More specifically it has helped the Therapist become more aware of formulating such as transference (the presenting past experiences affecting the present), countertransference (subjective/objective), defenses, attachment styles, observation and Phantasy/inner world experiences, when it is appropriate to bring the unconscious into the here and now for awareness, whilst setting a therapeutic frame for engagement and emotional linking. Overall the client-therapist relationship is central to the therapeutic process/ psychodynamic work as it gives Counselling Psychologist' an understanding of where the client has been (past) and where the client wants to go (future). The snapshots given throughout this essay shows the feelings expressed within this working alliance was of a good nature, that a bond was developing, trust was forming and engagement was on its way. In an autonomous and reflexive manner this has been a good starting ground for integrative work as one is still learning the ropes with applying such an application of psychodynamic measures.

Word Count: 3,005

Appendix A

Beginnings of a Psychodynamic Formulation: client- Poppy

Presenting Issue:

Poppy, seven years old referred to CAMHS within the Child and Family Services for hearing voices, has emotional turmoil, anger/rage against self, has three different personalities: the good, the bad and the representation of biological Mother.

History

-Biological Mother has ADHD and Tourette syndrome, Mother has abandoned and rejected client. Has an older child from previous relationship; who is autistic and had a difficult pregnancy with Poppy leading to post natal depression.
-Biological Father (both of his parents are first cousins)- incest. Dad has own identity issues surrounding his parental upbringing.
-Poppy is made to feel special as she was planned and her other siblings were not.
-Step Mother has a tendency to bare children and they end up in care.
-Biological Father abandoned his children and left them with Paternal Grandparents when the split was announced from biological Mother.
-Mental Health issues are wide spread amongst both biological Parents and step Mother.

Early Experiences: (traumatic)

-Physical abuse – biological mother threw a bowl at poppy's head, force-fed her, threw her across the room
-Emotional abuse- neglected her, days without care, projection identification from father in terms of power, all his pent up frustrations from mother has formulated onto client often bringing his own harmful knowledge/experiences to the clients' awareness.

Parental Relationships/Attachment style:
Ambivalent-Avoidant for both biological Parents as well as Poppy, which makes client often feel uneasy and aware of others e.g. forming relationships is difficult, will not invest in others of fear of rejection and abandonment. This is obvious with significant figures such as her other siblings.
-Dad often plays the Rescuer but when he gets annoyed lets her become the rescuer by giving her parental responsibilities of looking after other siblings whilst he plays the victim. Which leads the client to a 'persecuting' manner towards the Therapist at times.

Transference:

Malan's Triangle (1995)- hidden feelings (repression, hurt, anger, frustration) **Anxiety** (psychological and emotional pain comes out through her conflict of seeing her self as all good or all bad) **Defense** (avoidance-denial, projection; always makes out everything is ok, life is spectacular, all is well in her inner world,) symptoms can thus be formed in unhealthy manifestations in the external world when her defenses are being ignored or are not working causing tantrums and abuse upon herself.

Phantasy/inner world:

A need to be 'special', no real bond or emotional ties with her other siblings, she wants to be on her own and to continue to be made 'special' in a structured, cohesive, desperately wanting to cling onto a 'normal' family environment e.g. a mum, a dad and just her.

Countertransference:

Hurt and anger due to the emotional neglect by mother.
Wanted to be the rescuer, a Mother Figure wanting to be (protective, nurturing, caring, give emotional stability).

Object relation:

The therapist probably reminds client that she is another figure that may come into her world and perhaps abandon, hurt and reject her.

References:

Ayala, N. (2005). Transference and relationship: Technical Implications in the psychoanalytic process with a borderline patient. *International Forum of Psychoanalysis*. 14: 36-44

Barahona, R. (2004). Conflict and Deficit in Modern Psychoanalysis. *Modern Psychoanalysis*. *29*(2), 271-294.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development.* New York: Basic Books.

British Psychological Society (2009). *Code of Ethics and Conduct Guidance*. Leicester:

Cartwright, C. (2011). Transference, countertransference, and reflective practice in cognitive therapy. *Clinical Psychologist* 15: 112-120

Cashdan, S. (1988). *Object Relations Therapy: Using the relationship*. USA: Norton.

Coatsworth, J., Santisteban, D., Mcbride, C., & Szapocznik, J. (2001). Brief strategic family therapy versus community control: Engagement, retention, and an exploration of the moderating role of adolescent symptom severity. *Family Process, 40*(3), 313-332.

Daniel, S. (2006). Adult attachment patterns and individual psychotherapy: A review. *Clinical Psychology Review, 26,* 968-984.

Dreher, A.U. (2003). What does conceptual research have to offer? In Leuzinger Bohleber, M., Dreher, A.U., and Canostri, J. (Eds.) *Pluralism and unity.* London: IPA.

Freud, S. (1914). On the history of the psycho-analytic movement. *The complete psychological works of Sigmund Freud*, 14, 7-66. London: Hogarth

Gill, M. (1983). The point of view of psychoanalysis: Energy discharge or person? *Psychoanalysis and Contemporary Thought,* 6, 523-551.

Gutheil, T. G., & Gabbard, G. O. (1998). Misuses and misunderstandings of boundary theory in clinical and regulatory settings. *American Journal of Psychiatry,* 155, 409-414.

Hayes, J. (2006). The inner world of the psychotherapist: A program of research on countertransference, *Psychotherapy Research*, *14*(1), 21-36.

Higham, J; Friedlander, M; Escudero, V & Diamond, G. (2012). Engaging reluctant adolescents in family therapy: an exploratory study of in-session processes of change. *Journal of Family Therapy, 34*(1), 24-52.

Holmqvist, R., & Armelius, B. (1996). Sources of Therapists' Countertransference Feelings, *Psychotherapy Research*, *6*(1), 70-78

Jacobs, M. (1985). *The Presenting Past: An Introduction to Practical Psychodynamic Counseling.* London: Sage.

Jacobs, M. (1999). Psychodynamic Counselling in Action (2nd ed.) London: Sage.

Jones, A. (2004) Transference and Countertransference. *Perspectives in Psychiatric Care*, *40*(1), 13-19

Larsson, P (2012). How important is an understanding of the client's early attachment experience to the psychodynamic practice of counselling psychology? *Counselling Psychology Review, 27*(1)

Mearns, D. & Thorne, B. (2007). *Person-Centred Counselling in Action (3rd Ed.)* London: SAGE

Mitchell, S. & Black, M. (1995). *Freud and Beyond: A History of Modern Psychoanalytic Thought.* Basic Books.

Piovano, B. (2008). The function of the analyst's boundaries in the psychoanalytic relationship. *International Forum of Psychoanalysis*, 17: 91-103

Racker, H. (1957). The meanings and uses of countertransference. *Psychoanalytic Quarterly, 26,* 303-357

Schermer, V. (2011). Interpreting psychoanalytic Interpretation: a Fourfold perspective. *Psychoanalytic Review, 98*(6)

Wallerstein, R.S. (2009) What kind of research in psychoanalytic science? *International Journal of Psychoanalysis,* 90, 109 -133

Therapeutic Issues & Ethics
PS5001

Dec 2012

(Word count: 2,986)

Module Leader: Garrett Kennedy

Drusilla Joseph - Counselling Psychologist in Training
Student number: 1205937
D.Joseph@wlv.ac.uk

Therapeutic Issues & Ethics

Introduction

As Dryden (1985) points out a "Dilemma: [is] a position of doubt or perplexity. A choice between two (or among several) alternatives all of which have some unfavourable elements." (p1) Therefore within this essay one will (through the process of reflection) describe a dilemma presented via a case study tying in the aspects of practical and moral ethics; not only reflexively, but therapeutically, professionally and legally.
One must remember that an established ethical framework is a reminder of compositional boundaries coded and placed to "primarily guide not to punish" (BPS, 2009; p5) adjectival titles such as Counselling Psychologists. Hence performing Therapy at its very best in a cohesive, safe and competent way is a privileged experience to have. The gift of being able to hold an environment, manage the clients' needs and engage with relational depth perhaps poises ones' own recognition, acceptance and awareness that having an ethical framework reassures that whilst it holds us, we can also hold our clients.
This however can sometimes come nonetheless at a costly price. What if "this closely supportive structure peels away slowly, or is abandoned" (Coltart, 1993; p 5) by which all of our protective layers encapsulated under an umbrella of registered professional bodies may seem as if they are slipping away, dissipating, being rocked or shaken due to dilemmas of decision-making dexterities, ethical professionalism, or the clients' own internal world reflectively impinging (what it may seem like) the Therapists' future.
One case in mind (as listed below) brings about the very nature of such a debate.

Reflexively

Case Study

MB, male, 50, unemployed, living on benefits, came to see me (the Trainee Therapist) through a referral of his GP. Through the process of an Assessment, consent, Formulation,

additional psychometric testing such as GAD7, PHQ-9, WSAS and care clustering, MB suffered severe depression with suicidal ideation. To better understand his needs an additional risk assessment was taken focusing on his likely act of such thoughts, if harming of self of others were present, as well as if there were any preparations or plans with ending his life. As proposed by the BPS (2009) "Psychologists are likely to need to make decisions in difficult, changing and unclear situations." (p 4) Here the critical understanding of following professional protocols and procedures in line with the employers criteria by which keeping all parties (client, therapist and organisation) in a realm of safety was a heavy burden to bare, but conversely a realistic one being faced. The organisations' measurable accountability for the clients' well being extended to having a care plan put in place. The multi-dimensional struggles one had as a human being first and foremost; placed my internal presence at a point of distress, thinking quick on ones feet to ensure this unfavourable mind-set be safe, imprisoned my need to rescue him as a person (to hold him, take away the pain and frustrations) not as a professional body (to exercise an authoritarian organisation). The care plan thus consisted of checking in with MB on a time and day that best suited him, emergency numbers were given as preventative resources; for example out of office GP's, Samaritans, walk in clinics etc. and the organisations' internal crisis team were also informed.

In spite of this the shift in the clients' progress came at a standstill when his demands became imminent. MB wanted to come off of the care plan, complaining it was not working, he became deflective, withdrawn and challenging within sessions. One session in particular he placed much angst on me morally. Stating he could understand and empathise with 'those of the columbine high school shooting and can understand why they did what they did', that 'there is no point in living' and continued by expressing 'after this session and with comments like that you'll want to institutionalise me; won't you?' Alarm bells and an automatic red flag became apparent within me, as one then began to question ones' own safety with such a revelation and with such close proximity. Yet one proceeded by asking immediately 'After this session do you have any plans/intentions to harm yourself or anyone else? MB responded 'I have no intentions to harm anyone else, but I

cannot promise you I won't harm or kill myself, as I don't know'. To intensify the situation MB ended the session early by leaving. This indeed placed me in a position of ambiguous uncertainty as a decision had to be made sooner rather than later.

Psychologically and emotionally one felt stuck with an added pinch of nervousness. On the one had you needed to follow the organisations policies for risk to keep the client safe, but on the other hand you have a client trying to be autonomous for his own needs, but not in the most healthiest of ways. His own uncertainty ('I just don't know') made me uncertain as to what to do next. As the Code of ethics and conduct (2009) point out "the thinking behind ethical decisions needs to be clear, especially when time is short and /or where high levels of emotion and risk are involved" (p 8). A critical decision thus had to be made as many things were swirling around ones' head. 'Should one break client consent and inform my Supervisor without client knowledge?' 'How will this affect the therapeutic relationship?' 'What if he does kill himself, am I responsible?' 'If I do not inform someone, one will be liable for someone's life or other lives.' MB leaving me in a state of confusion, with the added pressures of my supervisor not being accessible right there and then, as well as this being my first such experience, one was not sure of the right thing to do. One could not physically hold MB down within the session, nor could one enforce that sticking with the care plan was the best solution for him, still telling my supervisor seemed appropriate and inappropriate all at once. This was due to the issue of confidentiality, trust and safeguarding. Lindsay & Clark (1999) put it best by stating "the need to reconcile the benefits of maintaining confidentiality to ensure trust and hence effective psychotherapy and intervention, compared with the need to protect the client and others from harm" (p 183) was where one found oneself. Being made to feel stuck between a rock and a hard place.

Professionally

This uncontrollable fear of ones' own ideation that this may be deemed as bad practice (that one should have done more perhaps to make him stay and not leave on that day) and what this may mean for me professionally also provided an influx of doubt and worry. As Jenkins (1997) assures "at certain points, ethical principles regarding client autonomy and

avoiding harm may conflict, as in the case of suicide prevention" (p 9) therefore my moral compass directed me to break confidentiality to my supervisor as noted by the HCPC (2012) "The safety of service users must come before any personal or professional loyalties at all times. [As] you are responsible for your professional conduct, any care or advice you provide, and any failure to act. You are responsible for the appropriateness of your decision to delegate a task. You must be able to justify your decisions if asked to." (p 8) The fact of the matter was; one knew this would mean the workings or buildings of the therapeutic alliance would be seen as misguided, untrustworthy and perhaps neglectful from MB's perspective. Yet this present dilemma of breaking confidentiality was geared for the greater good.

Having spoken to my supervisor he reinforced the services' policies which pointed me into the direction of writing up my notes, continue to call MB provided through the care plan, write to his GP and further to that write a letter to MB offering him another sessional appointment. Upon receiving the first letter MB called the service to cancel the appointment, but instead rescheduled for the following week. A second letter was thus drafted and sent out projecting the terms of the services' cancelation policies and DNA procedures (as instructed by the admin team and my supervisor). Jones (2003) admits that the "demands from outside the therapy room that challenge the confidentiality of the therapeutic process can arise when therapists work as part of a team." (p 27) which continued to place one in a stream of ethical dilemmas. Additionally a plan of action was implemented where by my supervisor suggested one should have a joint session led by me, with MB, if he decides to turn up. During this period one contacted our internal multi-disciplinary group the 'well-being team' to gain insight into their world, what they do and how they operate as an alternative for MB just in case. Although not instructed to do so "the point here is that there is a philosophical, scientific and professional debate going on about the very soul of helping." (Coltart, 1993; p 13) Here it was indeed the immediacy of acting on behalf of my clients welfare, wanting to do my very best to protect him and perhaps some part of me felt guilty for letting him leave without a resolution, however Barker (2011) adds "only humans seem to anguish over 'dilemmas' or 'decisions', developing complex, often baffling, theories to explain their decision-making…as a result,

making decisions becomes the most challenging aspect of being alive and being human." (p 5) One needs to remember that ethical principles such as respect, competency, responsibility and integrity were exercised. That by recognising my limits one sought to resolve the above dilemma by using appropriate means of reflection, supervision and consultation (BPS, 2009)

Therapeutically

This unpredictable often contrarian client would be resistant and reluctant in our one- on-one therapeutic space, time and time again over our eight sessions together. The influx of making progress then digressing backwards like a roller coaster often shifted the interplay between our ever-evolving relationship dynamic. Nevertheless the challenges were a great learning ground for the both of us as no matter how small the progress was, it was a gift offered and accepted by MB. Even so, this one-on-one trust seemed to dispel within my clients eyes as I approached him in the waiting room of his scheduled appointment, by discussing the factor that my supervisor will be sat in on our session to give heed onto the next stages of our therapeutic interventions as well as MB's overall well-being.

Finally being sat opposite me in what was our therapeutic space, now became almost a defensive, contaminated formal opposition, one felt the dilemma of being sandwiched between having a professional alliance and a therapeutic alliance. Expressing an impartial voice proved difficult as measuring up to the services expectations and tackling to reconnect with my client created immense difficulty between the three of us. Further and further barriers were manifesting such as (what it felt my client felt) an 'us' versus 'him' or an in-group versus out-group scenario; one did feel like one had lost him somehow. MB's comments on the services' letters and their DNA policies were instinctively blamed and targeted towards me due to my name being signed at the bottom. MB regarded this as a 'belittling slap in the face' that he thought 'I of all people would not be caught up in the organisations policies' and began to read the letter out in a hostile yet diplomatic voice, what MB failed to realise was one did use a standardised letter by my organisation, but one also catered the letter to his personal needs, one felt in this moment "…the building of the

working alliance and the likelihood of establishing psychological contact [were now lost]." (Jones, 2003; p22) One was not sure if the therapeutic relationship was strong enough to get through such an ordeal, but it was ones' job, duty and responsibility to act as a catalyst to help problem-manage the dialogue that would help MB find his own answers (Egan; 2007). These ethical principles in reasoning and decision-making came about due to ones awareness of MB's anger, frustration and disappointment. It was the battle of knowing that "Therapists have an ethical and moral responsibility to be trustworthy within the therapeutic relationship (fidelity)" (Jones, 2003; p24) which urged the art of finding that once again between us versus having the courage and "ability to *communicate* empathetic understanding…[as in this] instance a common language [needed to] be found." (Ardenne & Mahtani; 1989; p 71) Much to MB's dismay one stated that one would be handing him over to my supervisor (with MB's permission) as one was leaving the service, that there seemed to be unfinished therapeutic work and the fact that his safety needed re-addressing. A product of added anxiety both on my part (hoping he will keep himself safe until seeing my supervisor in the future as he would be placed back onto the services' waiting list) and partly the anxiety MB may have felt knowing one was leaving him in perhaps such a vulnerable state, one thus questioned ones' own abilities upon reflection; for example 'Did I push too hard within sessions? 'Did I challenge too much?' 'Did I not listen enough?' Does he think I am leaving him? 'Giving up?'

Overall the transitional shift from me to my supervisor in the therapeutic space, as an introduction for what lays ahead for MB was a tense, but movable transfer. As my client held onto me, I held onto my supervisor and my supervisor held onto my client. The responsibility and obligation of supporting each other was a necessary containment yet the principality of someone letting go would be another foreseeable predicament. At this time one got the sense that the traditional help that one was trying to provide was merely a drop in the ocean for MB as this space and outlet which seemed to be a positive one, competed/battled in the midst of a whole host of negative experiences both at present and in the past. (Dryden; 1985)

Legally

Throughout this process one very much thought about the legality of this therapeutic work. The fear of my client killing himself, other people, or a complaint from his part about the service could have escalated resulting in a devastating ending, which would inevitably have caused a domino effect producing worry for families involved, my future career, practice, current influx of reflections on the organisation, my supervisor, my human dignity and "it may…raise issues of the wider public interest…and to the community generally." (Clarke, 1990; p 23) One would overall be accountable and labelled unfit to practice, as a liable investigation might have taken place due to any of those outcomes. My clients' extended family members could have hired a lawyer "proving that the lack of care actually *caused* the clients' worsened depression, or suicide attempt or other adverse effect" (Jenkins, 1997; p 43) or the victims' families pressing charges. A court could thus order me to testify about the discussions and interventions made or used within therapy as well as my therapy records and notes that were kept. Here it would also have been the dilemma of "the general legal requirements concerning the giving and withholding of information" (BPS, DCoP, 2002; p 4). This would likely be a time constraining and realistic decision one would have to face. With this case of MB, ones' negative automatic thoughts spiralling out of control could not be helped, as the churning sensation within me knew that the "best practice and prudence in a legal sense would suggest that therapists avoid doing anything which would damage their clients, or which would cause additional damage to an already vulnerable person."(Jenkins, 1997; p 44) Bearing this in mind one hung unto the idea that all of this gave me a sense of awareness beyond the therapy room, space and organisation. That there was invaluable learning throughout this heavy predicament and understanding its' purpose was key.

Conclusion

One forgets "just how much there is to learn, especially when one is extremely ignorant of the whole field." (Coltart, 1993; p 8) This statement is true enough when faced with the consistent onset of potentialities and factors of what happens *if* or *when* something goes

wrong "it makes a pertinent distinction between a mistake and negligence, which can merge into one concept if they are not clearly considered." (Gower, 1999; p 339) often "there is a great temptation to have an answer to ethical dilemmas, indeed to seek an ethical code that answers all the issues raised." (West, 2002; p 4) yet as this is not so and ethical dilemmas or decision making can thus come in all forms; it is with care, respect, confidence, integrity, dignity and self-sufficiency which makes ethical dilemmas revisable within this body of work and can be dealt with practically; as it is held in a framework underpinned with stamped protection. As a Trainee Therapist the overall conclusion one has reflected upon throughout this process of therapeutic and practical considerations would be that it is about putting your best foot forward, being competent, justifying your reasoning and decision making every time, making and keeping vigilant case notes, more importantly sticking to your clients' goals and their well-being. Barker (2011) makes it clear that "ethics can be a disturbing business…[it] involves enacting our private thoughts about ourselves, others and the world around us." (p 5) nonetheless it is embedded within us to help determine what the right thing to do is, as it "governs most areas of everyday human life." (Barker, 2011; p 6) On that note, we as Counselling Psychologists have to remember that to remain in such a vital pivotal position in the context of therapeutic work and professionalism it is a demanding, challenging yet rewarding experience and it is having the sense of readiness and knowing which way to turn to in times of ethical dilemmas that is paramount.

Word Count: 2,986

References

Ardenne, P d' & Mahtani, A. (1989). Transcultural Counselling in Action. London, Sage.

Barker, P.(2011). Mental Health Ethics: The human Context

BPS, (2009). *Code of Ethics and Conduct Guidance*. Leicester: British Psychological Society

BPS, DCoP (2002). *Professional Practice Guidelines.* Leicester: British Psychological Society.

Coltart, N. (1993). How to Survive as a Psychotherapist. London, Sheldon.

Clarke, L. (1990). Confidentiality and the Law. Lloyds of London Press Ltd

Dryden, W. (1995). The Stresses of Counselling in Action. London, Sage.

Dryden, W. (1985). Therapists' Dilemmas. London, Harper Row.

Egan, G. (2007) The Skilled Helper: A problem-management and Opportunity-development approach to helping. USA. Thomson brooks/cole

Gower, B. (1999) Complaints and Grievances in Psychotherapy: Handbook of ethical practice. Sexual and Marital Therapy. 14 (3) 339-

HCPC. (2012). *Standards of conduct, performance and ethics*. London: Health & Care Professions Council.

Jenkins, P. (1997). Counselling. Psychotherapy and the Law.

Jones, C. (2003) Forms of Ethical Thinking in Therapeutic Practice. Berkshire

Lindsay, G & Clarkson, P (1999). Ethical dilemmas of psychotherapists. 12, 182-185

West, W. (2002). Some ethical dilemmas in counselling and counselling research. *British Journal of Guidance and Counselling, 30*(3), 261-268.

The Research Dossier

An exploration of Counselling Psychologists' experiences of subjective and objective countertransference and how this impacts the therapeutic process

By

Drusilla Joseph

Literature review

Introduction

Countertransference, a concept regarded as the emotional entanglement of a psychotherapist's feelings towards a client has received high levels of attention in the psychoanalytic and post-psychoanalytic literature. Also its significance in therapeutic relationship cannot be deemphasized. The main focus of this work is to explore the world of counselling psychologists', their experiences of subjective and objective countertransference within clinical practice and how this impacts the therapeutic process. Firstly the researcher explores other predominant areas such as the role of the clients' transference, the interplay between transference and countertransference within the therapeutic alliance as well as the role of congruency to give the reader a substantial understanding of the positioning countertransference plays systemically. Further to this the following chapter explores the existing debates that surround the *conceptual* framework known as countertransference, this will include a literature review of countertransference showcasing empirical research so far and gaps for further exploration regarding therapeutic focus.

The role of Transference

The strength of an in-depth, relational therapeutic relationship and maintaining a 'good-enough' working alliance begins at the outset of a clients' transference. Transference therefore resides from the classical psychoanalytic theorist Sigmund Freud (1905/1953). Freud (1905/1953) saw transference as a reoccurrence of dynamic repressions (known as the oedipal complex) unconsciously carried by the client in which they bring into the therapeutic space and impact the working alliance (the relationship between therapist and client). Both Stolorow and Lachmann (1984), with Stolorow (1991) evolved the nature of this definition by calling attention to the role therapists' also play and how it affects' the clients' experience of the working relationship. The role of transference therefore affects the therapists' evoked reactions and responses known as countertransference within the

contained space. Vice versa the countertransference (once experienced) further forms a perpetual cycle on the inter-subjective nature of transference (Markin, 2009), giving a *to and fro* affect between the client and therapist. By large the interplay between these two delicate, intricate and beneficial components (transference and countertransference) shapes the therapeutic alliance not only in the moment of experiencing them, but throughout the duration of a session and the outcome of the overall therapeutic process. It is worth noting then that transference and countertransference consequently has the power to shift the pace and conclusion of the therapeutic alliance (Corey & Corey, 2002; Yalom & Leszcz, 2005; Wampold, 2010).

The role of countertransference

Unlike transference, countertransference has many conceptual definitions' which seem to evoke scholarly debate. As noted by Hayes (2004) "…scholars have spent more energy wrangling about definitions than conducting research; countertransference is extremely difficult to measure; and therapists can manifest considerable resistance to empirical scrutiny…" (p 22).

Conversely the endless deliberation over what countertransference means thus poses the question of how one can advance in research, which direction is then best suited for adding further new value to this area and what then are we seeking in research if the base line has endless streams of inconsistent conceptual definitions? The downfall then by taking on one scholarly definition is that empirical findings may be dismissed or deployed.

However, one needs to be well aware of the primary understanding of countertransference and its' many conceptual definitions in order to pursue research. The beginning works of Sigmund Freud who first introduced countertransference and conceptually identified it as the *Classical view,* pointed out that countertransference primarily is the therapists' own blind spots that realistically confine their capacity to make clear analytical judgments (Nissen-Lie & Sta¨nicke, 2014; Hayes & Gelso, 2001) and that the client's transference somehow stimulates the therapists' childhood which happen to be unresolved (Hayes,

2001; Fauth & Hayes, 2006). Within this classical framework, countertransference was often quickly avoided, was thought of as harmful to the therapist-client relationship and its' existence was considered a weakness that the therapist needed to overcome in order to conduct effective therapy.

Although the *Classical view* dominated the psychoanalytic world for quite sometime, other emerging analysts felt that the classical definition was too restrictive (Fromm-Reichman, 1948; Heimann, 1950; Little, 1951; Winnicott, 1949) and instead defined countertransference as the therapists' emotional reaction towards the client. This was coined the *Totalistic view* (Heimann, 1950; Racker, 1957; Kernberg, 1965; Gabbard, 2001). Heimann (1950) who adopted this broader connotation suggested that the prefix of 'counter' implied that there were additional factors involved such as both transference (as mentioned above) and countertransference robustly complimenting one another giving insight into the clients' unconscious. Nevertheless, "Heimann regarded the countertransference as useful information [but] opposed the therapists' communicating his or her feelings to the patient" (Gabbard, 1999; p2). Given the centrality of such an issue (not congruently sharing with the client) this caused much stir amongst scholars who then attempted to portray this concept as perhaps being too vague or overly inclusive (Panken, 1981; Watkins, 1985). Contrary to this, countertransference shaped its' definitive presence by becoming the *Inter-subjective/Integrative* perspective in which Gabbard (2001) reported it to be a "jointly created [experience]" (p 984) by both the therapist and the client. Similarly, Nissen-Lie and Stanicke (2001) expressed that countertransference is the therapist's conscious and unconscious reactions to the patients' transference stemming only from their unresolved conflicts. This makes countertransference less narrow than Freud's *Classical* definition but more narrow than the *Totalistic* definition. There is the ultimate distinction that it is often difficult to draw between resolved and unresolved personal conflicts within a clinical setting. With this in mind, the researchers' own understanding of countertransference tailors more to the theoretical concept of an amalgamation of all three perspectives (the *classic view, totalisitc* and *inter-subjective* perspectives) as there is agreement between reactions having additional factors to contend with to get a robust understanding of what belongs to the therapist (their unresolved

conflicts and all emotional content) and equally gaining further insight into what belongs to the client (their transference). It is then up to the therapist to disseminate what feels authentic to the relationship. However, in the discussion of transference and countertransference in therapy, congruency cannot be deemphasized. The next section will focus on this concept as it relates to countertransference.

The role of congruency

The role of congruency therefore plays a huge part in the counselling psychology provision. *Congruence* is seen as a *state of being* (Mearns and Thorne, 1988), where the self is a holistic component that encompasses experiences/influences and can genuinely express this *state* just as it is, to engage with clients for a willingness of self-exploration, honesty and revelations (Wilkins, 1997). This is where the foundational base of the counselling psychology stems from for practical use of *the self* within therapy. Countertransference on the other hand is the unconscious underpinnings or reactions to the clients' transference which may impinge on the therapeutic relationship and its' process. If this is the case it is worth highlighting then what countertransference brings to the humanistic/person centred being. As there has been a paradigm shift in the way countertransference is defined, such as the *classical view (*which psychoanalysts could not enter the process of conveying how they felt to their clients), to a more open ended dialogue implied by the *Totalistic view* and the *Inter-subjective/Integrative* perspective. Counselling psychologists' therefore can benefit from sharing blind spots transparently (to aid clinical practice when using this specified orientation), and fully become present with the client in understanding hidden meanings which inevitably contributes to the person-centred approach (to be congruent).

Reasons for undertaking this study

Finding out therefore what parts of countertransference belongs to whom (therapist or client), how we bracket these off and what occurs within each for congruency is the central focus in order to move research forward. Nonetheless in order to do this the researcher wants to know 'as individuals experiencing a range of human emotions in their personal and professional lives, how emotionally involved can a counselling psychologist be with a client?'

To answer this question a plethora of factors are considered. For example, what the client brings to the space (transference) may become emotionally challenging, that it not only objectively moves the therapist, but at times subjectively it may take a deeper meaning and impact on the therapists' own early or unresolved experiences. The intention and the motivation on moving the therapeutic relationship forward then relies on how the content has left the therapist feeling and if they can authentically address the materials arising. Although this may sound as though the therapist has a great amount of power, the concept of countertransference underlies the need for counselling psychologists' to be a reflective and reflexive practitioner. The principles of reflexivity suggest the importance of exploring ones feeling. If countertransference occurs in practice without self-awareness and monitoring of the practitioner, the consequence may become problematic. As it has been stated countertransference having originated with the understanding that it was deemed inappropriate for the analyst to respond or react to evoked feelings and was often discouraged from entering into the therapeutic process (Dahl et al, 2011). Over the years with different paradigm shifts, there has been more and more growing acknowledgment of utilising countertransference within clinical practice due to an understanding that countertransference is powerful and inescapable. It can impact the therapist, client, therapeutic space, working alliance, maintenance/management of the process and often the outcome of therapy.

Counselling psychologists' are unique in so far as positioning themselves between the science of psychology and the therapeutic practices of counselling & psychotherapy. A

counselling psychology identity has developed which espouses the complementary aspects of 'scientist practitioner' and 'reflective practitioner' (Woolfe, *et al,* 2010), which aligns with placing high value on the use of *self* through practicing humanistic values and the understanding of subjective and inter-subjective factors that contribute to the interplay of the therapeutic relationship (Rizq & Target, 2009). Counselling psychologists' moreover have an integrative way of *being* by opening up these parts of themselves to help facilitate psychological contact with clients. Tapping into evoked feelings brings about grounds for new learning, growth and understanding of how practitioners impact/influence the process of the therapeutic relationship. The greater chance of knowing what is going on internally may lead to a greater opportunity for sharing and increasing evidence-based practices.

Hence, it is worth noting that counselling psychologists' are especially invested in questions of epistemology (Shorrock, 2011) by conducting this particular research it is a representation of how counselling psychologists' primarily experience evoked feelings that inform clinical practice. In fact we are central to holding and containing our clients, but how do we hold and contain ourselves? What goes on in the *self*, which gives permission to withdraw or connect with clients emotionally? Biancoli (2002) puts it best by stating that as a member of the human race, every individual has the potential to fundamentally experience every human experience, but the same experiences may convey different meanings. Therefore the idea of a collective consciousness also has a byproduct of individuality, which this research reflects.

This research hopefully shows counselling psychology as a profession, with a specialist focus on paying particular attention to the meanings, beliefs, context and processes that are constructed both within and between people (British Psychological Society, 2010). This is achieved through the examination of the counselling psychologists' affective approach, their ability to remain involved with the therapeutic process whilst experiencing complex material and how they maintained empathic engagement. This project therefore explores the nature of countertransference to allow purposeful and authentic self-disclosure.

Literature review of Countertransference research

This section presents a synthesis of relevant research papers on countertransference that provides reports of empirical efforts to capture countertransference in a variety of contexts. As countertransference is broad and there are huge amounts of scope to consider such as age, gender, classification, diagnosis, methodology and demographic population; that will affect the process, relationship, management and outcome of the progressive treatment. The review of the literature therefore involved extracting respective papers which highlight the direction that countertransference has taken and is taking to better narrow future endeavours. The inclusion criteria consisted of; empirical papers (both quantitative & qualitative) written in English, dated between 1997-2013, with children/adults within the mental health population, involved in one to one therapy, using several electronic databases (Academic Search Complete, Science Direct, PsyINFO and CINAHL) to obtain key words to aid the process such as 'countertransference (psychology)', 'subjective-countertransference', 'objective-countertransference', and 'countertransference-management', exclusion criteria involve forums, anything that is not published in English, theoretical papers, clients involved in group or systemic family therapy and book reviews.

Brief Laboratory Research on Countertransference

It appears that countertransference is one of those phenomena that continue to spark clinical interest; whether this is predominant in this day and age or during the time of Freud. Remarkably, there have been many ways in which there were attempts to understand this concept and apply it to practical use. One pivotal published research review of countertransference written by Singer and Luborsky (1977) acknowledged many sufficient findings prior to the time when empirical research was laboratory based, often attempting to replicate or stimulate, under controlled conditions, situations that occurred naturally in real life. Therefore several influential studies focused solely on behavioural manifestations of countertransference and used rather crude methodology to advance research (Rosenburger & Hayes, 2002)

On logical grounds there is no compelling reason to argue that lab studies did not serve a great purpose as an indicator to countertransference (especially the most common studies being of *state anxiety* as a countertransference reaction). However it limited the exploration of other *affective* concerns, for example love, tiredness and sadness, within the therapeutic frame as contributory factors to building countertransference. Nevertheless these studies not only focused on behavioural manifestations, they failed to explore cognitive functions and real clinical settings/practices, which limited the external validity (Rosenburger & Hayes, 2002).

Brief overview of Field Research Conducted on Countertransference

Consequently, field research took a different direction by collecting information outside of the laboratory. In 1987, McClure and Hodge attempted to develop a measurement strategy where they captured counselors' perceptions of themselves and their clients. They recruited 12 counselors and 36 clients asking them to complete a personality inventory. In this study, they also explored and examined the relationship between countertransference and counselors attitudes towards their clients. These investigators concluded that strong positive feelings towards their clients equaled misperceiving clients as "overly similar to themselves" (Rosenburger & Hayes, 2002; p268) whereas negative feelings were equaled to being dissimilar to themselves. Here we can see that perhaps personality biases blurred lines of judgment in both circumstances. Having an objective view of ones own self may have been contaminated with subjective experience (such as having strong feelings, for example, towards a client) which does not necessarily mean they become similar to ones' self, but in part have 'hooked' (Kiesler, 2001; Gabbard, 2004) onto a transferred feeling. This may have overshadowed their clinical judgment or perhaps the far more intricate and complex nature of the client reminding the therapist of someone they may already know or the therapist simply having a fondness for the client.

In contrast, Hayes, Riker and Ingram (1997) investigated the relationship between countertransference behavior and factors that facilitate countertransference management. Using 20 counselor trainees, 20 clients, as well as former supervisors to rate (through observation) their perceptions of the trainees' management abilities. Trainees were

administered a self-report questionnaire after each session to capture their own perceptions. Results indicated that *previous* supervisors' (who once had a supervisory relationship with the trainees) rated the trainees' empathy and self-integration as negative countertransference behavior. This indicates that depending on the type of supervisory relationship being built over time between supervisor and counselor it had an impact on not only the supervisor's perceptual judgments of what the supervisee was capable of, but their observatory interpretation, was just that, an 'observation' and would be hard to capture considering countertransference is evoked and experienced (rather than observed). Perhaps a state of cognitive dual processing by the supervisor may have blurred scores given to trainees. This of course will have some impact on the findings. Up until this point it was clear that quantitative measures were far more justifiable and perhaps reliable than qualitative methods which explained why it was used in this study. Here countertransference was also beginning to incorporate other empirical dimensions such as supervision to contribute to its' measurement and positioning.

Nonetheless, Williams et.al (1997) moved away from the quantitative methods and instead studied the experiences of trainees with a combination of qualitative and quantitative methodologies over a period of a semester. This study enabled the much needed integration of both methodologies within a core study. The findings demonstrated changes in trainees' anxiety, self-efficacy, countertransference management, and therapeutic skills. More specifically the quantitative analysis indicated that trainees became less anxious and developed greater skills over the semester, where as qualitative analysis found that trainees experienced a range of reactions during sessions which inevitably distorted their perception to provide effective therapy and often managed their reactions by 1) using self-awareness 2) focusing on the client and 3) suppressing their own feelings and reactions. It appears that responding quantitatively fostered a natural surface-level reaction, whereas investigating qualitatively enabled deeper, rooted underlying assumptions to emerge. Cognitive theorists would call this natural surface-level reaction a system 1 function as it appears to be evaluated automatically, whereas qualitatively it allowed a greater awareness of reflective practice (system 2) through conscious and deliberate mental activity (Barrett, 2001; Kahneman, 2011). Here it seems that there was a clear distinction between the

combination of the methods employed and that the qualitative aspect not only gave a richer source of data but also hinted at the use of techniques to manage countertransference whilst experiencing it.

On the contrary, one research paradigm that stands out with investigating the rooted underlying assumptions of countertransference was conducted by Hayes, McCracken, McClanahan, Hill, Harp and Carozzoni (1998). They investigated a consensual field study in a qualitative format examining transcripts from interviews conducted with 8 psychologists immediately following their sessions of brief therapy with 8 clients. Analyses identified three countertransference components called *origins, triggers* and *manifestations* of the therapist. More specifically *origins* revealed categories of family/cultural/therapy-specific issues as well as needs and values (devaluing dependence.) *Triggers* included content of client material (parenting), therapist comparing client with others, change in therapy structure or procedures (sessions starting late), therapist assessing progress of therapy, therapist perception of client (positive, negative or dependent) and *manifestations* including categories of approach (nurturing), avoidance (blocked understanding), negative feelings (such as anger, frustration) and treatment planning. This study gives an in depth, detailed and intricate look at countertransference as to what maybe occurring within it and what brings about these reactions. However, due to therapy being brief it is difficult to ascertain how quickly these components could have arisen. Limitations of this study therefore point to questions of consistency and stability over time. Furthermore, results do not encompass all possibilities of countertransference origins, triggers and manifestations (but rather snippets) nor age, ethnicity, disability, language/linguistics and so forth.

In addition, Rosenburger and Hayes (2002) through investigative field work later concluded that the thematic content of what the client brings to the session, matched the therapist countertransference *origins*, which triggered therapist avoidance behaviour and impacted the therapeutic alliance within the session. This also left the therapist feeling less of an expert when clients talked of issues inversely related to therapists' unresolved conflicts. The same year Gelso, Latts, Gomez and Fassinger (2002) examined the

relationship between therapist countertransference management ability and therapy outcome. This recognised that therapists (with their unresolved conflicts) were at risk if they failed to contain their own countertransference responses (such as triggered avoidant behaviour as mentioned above), which ultimately will be a detriment to the working therapeutic relationship. Therefore 32 trainee therapists and their clinical supervisors took part in this particular study. Supervisors rated their supervisee through a Countertransference Factors Inventory (CFI): assessing five characteristics of countertransference management. These were self-insight, self-integration, anxiety management, empathy and conceptualizing skills. The counselling outcome was assessed by a Likert scale called the Counselling Outcome Measure (COM), results indicated in a quantitative measure that subscales of anxiety management and conceptualizing skills were positively related to both trainee and supervisor ratings of outcome, whereas self-integration was related to trainee but not supervisor outcome ratings. However, 'managing countertransference' was investigated using quantitative measures observed from an objective perspective (supervisor observations) and failed to intrinsically and introspectively cater for the individual therapist. This is similar to the previous study explored and conducted by Hayes, Riker and Ingram (1997). With this in mind, countertransference may be considered an owned internal process that belongs to the individual feeling/experiencing it and this research design moves away from that.

Walker (2004) explored the impact of working with trauma (survivors of childhood abuse) and paid particularly close attention to countertransference or counter-transferential responses in practitioners. These studies are ample support to preoccupied responses of thoughts and feelings within the sole framework of the practitioner rather than the client which relates back to the idea that failing to understand ones' self may lead to challenges in adequately serving the client, potentially leading to impacting the process and poor therapeutic outcome (Nissen-Lie & Stanicke, 2001)

To broaden the idea of preoccupied responses Betan, Heim, Conklin and Westen, (2005) investigated a random sample of 181 psychiatrists and clinical psychologists to perform a set of measures using a countertransference questionnaire on a randomly selected patient in

their care. This study assessed the clinicians' cognitive, affective and behavioural responses. Results found eight countertransference dimensions as follows 1) overwhelmed/ disorganized, 2) helpless/inadequate, 3) positive, 4) special/overinvolved, 5) sexualized, 6) disengaged, 7) parental/protective, and 8) criticized/mistreated. Significant correlations of countertransference responses were found across client groups in predictable patterns reporting that regardless of clinicians' therapeutic orientation similar responses can still emerge. As a rebuttal to this point, it might be argued that cognitive, affective and behavioural responses were advancing at this stage, with investigations focusing more broadly on countertransference as a whole rather than the affective or emotional responses, which are synonymous with countertransference. This data suggests on the other hand that countertransference is still considered as a whole, (cognitive, affective and behavioural), rather than separate parts (cognitive countertransference, affective countertransference and behavioural countertransference).

However, other researchers such as Rossberg, Karteruda, Pedersenc and Friisa (2010) have managed to investigate countertransference and its process. Rossberg *et al.* (2010) conducted a quantitative study where by countertransference reactions provided by therapists gave an important indication of both the patients' internal world and their diagnosis. Findings of this study suggest that in any given outcome or response produced by the therapist, results only inform objective countertransference, but fails to recognise or consider the subjective side. It also remains unclear whether transference played a part in producing the countertransference reactions in this instance.

Contrary to this, one study that did consider the underlying cause of transference and countertransference to comprehend the process was that of Tishby and Vered (2011). They provided evidence using a Core Conflictual Relationship Theme method (CCRT) to measure countertransference themes. The underlying premise of the CCRT was originally developed as a measure for assessing transference (Luborsky & Crits-Christoph, (1998), more specifically the patients early relational patterns with their parents which is often carried over into other subsequent relationships for example with their therapist. The central relationship patterns therefore consist of three components of the CCRT: wish,

response of other and response of self; deriving from relationship episodes described by the client in the case of transference (Luborsky & Crits-Christoph, 1998). This study however is the first study to test the CCRT's usefulness in investigating countertransference. This exploratory study recruited 12 therapists who sought preliminary answers to 3 research questions firstly describing relationship episodes with their parents and secondly with two of their clients. Results presented both quantitative and qualitative analyses of the interviews, of which the first two research questions were quantitative and the third question was a qualitative approach. To conclude the therapists rated high repetitiveness in central relationship themes with their parents appearing in their relationship with their clients. As psycho-analytic or psychodynamic work stems from attachment formations this study takes countertransference to its' original base, the *Classical View*, but moves it forward by narrowing the focus on unresolved conflicts for the therapist and how this may affect the overall therapeutic process. However moves away from the *totalistic* or the *Integrative* perspective, which are more modern ways of looking at countertransference.

Moreover, the following study gives tremendous revision to exploring the idea of using a longitudinal approach, which other studies have not yet attempted and highlights the maintenance of the therapeutic relationship over a period of time, which helps capture the 'alliance'. Dahl, Rosseberg, Bogwald, Gabbard and Hoglend (2012) more recently paid attention to the countertransference phenomena through empirical single-case studies. To assess the therapists emotional reaction, a self-report questionnaire comprising 58 feeling words and using a Feeling Word Checklist was structured for 6 therapist-participants who treated 75 patients over a longitudinal period of 1 year. Each checklist completed at the end of each session focused on the psychodynamic process of the intervention. Four factors emerged from their results, including: Confident, Inadequate, Parental and Disengaged. This study however, fails to give techniques on how to manage these four factors when they arise and how to control it so that it may not interfere with the therapeutic process.

From the reviews of empirical studies above, the evidence seems to suggest that countertransference has been wide spread in touching on various domains producing

paradigm shifts by generating food for thought on consistent branches of one area to the next. The foregoing discussion has involved laboratory work to fieldwork and from quantitative to qualitative methods and sometimes a combination of the two. Countertransference has been measured through its' curious nature of self-disclosure through reported perception, observatory perceptive management (supervision), emergence of both subjective and objective areas (although not consciously labelled). It has classified cognitive, affective and behavioural responses as a whole rather than funnelling them down into their separate components, as well as attaching itself onto the likes of transference rather than being researched separately and subjectively. Nonetheless the overall running theme throughout each significant paper leads to the lack of reflective practice when capturing such evoked experiences. Therefore the empirical research mentioned above are useful in broadening the understanding of countertransference and its' many directional dimensions. With this said it appears that the existing reviewed research needs much focus.

Future Research & Narrowing the Research Focus

Along similar lines, Markin, McCarthy and Barber (2012) argue that conflicting literature needs clarification in order for research to move forward. Future studies should concentrate on separate parts of countertransference such as feelings and behaviours, as well as types (positive versus negative) in both the instance of transference and countertransference as mentioned earlier in the beginning of the review. The relationship of transference and countertransference over time should also be measured with regards to how they relate to each other as this may impact on the treatment phase and therapy outcome.

Moreover, Ivey (2013) appropriately points out that there is increased attention from cognitive therapists discussing theory and evidence based techniques in understanding and managing reactions of countertransference. By examining these factors cognitive therapists are beginning to also discuss the cognitive conceptualization of countertransference. Cognitive theory differs by large from a psychoanalytic/psychodynamic approach therefore it is important not to get our wires crossed when examining the interplay of

countertransference from these two distinctive theoretical orientations. For example the term countertransference used by cognitive therapists in this contemporary day and age is conceptually understood and referred to as the therapists' evoked cognitive-affective responses or reactions to the client (Gabbard, 2004; Cooper, 2008). Examining mental processes alongside emotive responses rather than just the emotive reactions that psychoanalytic/psychodynamic therapists' present. It has also been noted that among cognitive therapist's, they refer to countertransference as a subjective form meaning that cognitive therapists only deal with the subjective aspect of countertransference. More specifically the personal schemas and core beliefs that underlie responses to clients' behaviours; a prime example of this would be Leahy's social-cognitive model (Leahy, 2007).

Introduction to subjective and objective Countertransference

Speaking of subjective and objective areas of countertransference referenced by Cartwright (2011) within a cognitive framework, it is clear that there is importance in considering both subjective and objective parts of countertransference within the working alliance (which cognitive therapist dismiss objectivity) even though each part has great significance. In addition as noted by Cartwright (2011), it is important that future directions continue to examine the concept of countertransference as this is a useful tool and holds validity to clinical practice. Complimentary to this, longitudinal studies need to focus more on psychologists' methods of managing countertransference responses both *subjectively* and *objectively*. Subsequently, there is room for exploring the impact that countertransference will have on the therapeutic relationship with the clients. Originally, Winnicott (1949) who introduced aspects of countertransference naming parts of it as *subjective* and *objective*, described the subjective aspect as "…the therapist's responses to the client based on the therapist's own personal issues. The *objective* aspect referred to the therapist's natural or realistic reaction to the client's personality or extreme behaviour" (Cartwright, 2011; p115).

The empirical research on 'Subjective' Countertransference

It is consequently important to review the literature around subjective and objective countertransference to investigate the substantial gap in the literature on what actually occurs during *subjective* and *objective* countertransference. This is to help bridge into a counselling psychologists/psychotherapeutic framework rather than just from a cognitive stance and not seeing countertransference just as a global whole, but more broadly in their individual parts to help practitioners understand and 'be with' countertransference in the collective 'moment' of experiencing it.

In this literature search there was noticeably a lack of empirical papers breaking down countertransference further into a *subjective* experience. Omylinska-Thurston and James (2011) led the way as Counselling Psychologists with a qualitative grounded theory approach, which examined person-centered practitioners exploration of how they process their inner experiences in the therapeutic relationship. The results indicated that the therapists processed their internal experiences in the therapeutic relationship through the stages of " receiving, processing, expressing and confirming" (p 23). The authors concluded that therapists have to have a high level of insight, self-awareness internally, be tuned internally and have internal discipline to be congruent within the relationship and perhaps not act-out or misuse countertransference from a *subjective* stance.

Laufer (2010) whose empirical study drew on phenomenological methodology, which investigated and interviewed psychoanalytic clinicians and their experiences in the therapeutic relationship with a psychotic patient, this resulted in positive countertransference. Nevertheless, there is overwhelming evidence from the work of Zachrisson (2009) and Karamanolaki (2012), corroborating the notion that *subjective* countertransference has to date been discussed from a theoretical standpoint. In fact, many conceptual investigators who are seemingly interested in *subjective* countertransference are by large Cognitive Therapists, for example Bennett- Levy and Thwaites (2007), Haarhoff (2006), Leahy (2007) rather than psychodynamic therapists or those who use the

psychodynamic approach/cognitive therapies such as clinical or counselling psychologists (as mentioned earlier) which suggests that there is room for much growth here.

The empirical research on 'Objective' Countertransference

A similar discovery was found with *objective* countertransference whereby a limited amount of empirical investigations were carried out (Betan et al. 2005). According to an overview demonstrated by Betan et al. (2005) cited in Cartwright and Read (2011) there has been *indirect* evidence to support the notion of objective countertransference through the means of some laboratory and non-clinical studies. For example Downey, Freitas, Michaelis, & Khouri, (1998) suggest through their study of an observational laboratory longitudinal romantic relationship (couples); women who had an expectation that their partners would reject them ultimately behaved in a manner that evoked rejection from their partners. Equally depressed clients,' who believed criticism from other people, usually matched their own way of looking at themselves (Swann, 1997). In conclusion, these limited studies provide (from the standpoint of a clinician) their *observational objective perspective* with regards to the effects of individual expectancies in a relationship rather than from a *direct experience of objective countertransference* involving the clinicians' feelings.

On the other hand countertransference responses to different client groups through small clinical studies have also been highlighted such as Colson, Allen, Coyne, Dexter, Jehl, Mayer et al. (1986). They investigated emotional reactions from hospital staff to 127 clients on long-term in-patient units with different diagnostic groups. Results concluded that there was much *anger* towards clients diagnosed with personality disorders, *hopelessness* with those experiencing psychotic withdrawals and *protectiveness* towards clients' with suicidal depression. These results brought awareness of division among staff (due to their array of demonstrated emotions) and sometimes added difficulty of providing treatment for the clients.

Likewise, Brody and Faber (1996) empirically researched the effects of therapists' experience and patient diagnosis on countertransference. Therefore 336 therapists

(including clinicians and students) completed questionnaires to assess their attitudes and emotional reactions to clients in treatment and also to case vignettes. Results indicated that depressed clients predominantly evoked *positive countertransference* from therapists. Borderline clients stirred up mostly *anger* and *irritation* whilst schizophrenic clients evoked a *complex mix* of countertransference feelings.

However, recent researchers' such as Cartwright and Read (2011) investigated a five-step method designed to facilitate therapeutic understanding and management of countertransference. As mentioned within the study of Brody and Faber (1996) therapists' at early professional development (students in particular) had difficulty managing countertransference responses (whether subjective or objective) and upon reflection realised that their strongest emotional reactions were often regret about what they were more likely to say to client's. Therefore Cartwright and Read (2011) provided psychologists with a way of considering their own countertransference reactions. These were 1) awareness 2) recognition of objective countertransference 3) develop hypothesis about the transference /countertransference (by using key questions) 4) employ calming strategies (such as mindfulness) and then 5) therapist should adopt the transactional analytical concept of the adult phase to move on. However, this fails to explore what is actually occurring subjectively or objectively, which arguably is needed in order to apply these stages. Although Cartwright and Read (2011) argued that " subjective and objective countertransference responses may be intertwined in actuality, it is important to have systematic methods for considering both " (p 47). In order to systematically consider both one needs to shed light on investigating *subjective* and *objective* occurrences separately.

In 2012, Hafkensheid assessed *objective* countertransference reactions by using a diagnostic computer aided device known as the Impact Message Inventory (IMI-C). The IMI-C has the capability of producing scores that are generalizable across different therapists involved with the same patients and has become a user-friendly clinical instrument for the assessment of patient induced countertransference reactions (p 37). Given the centrality of investigating this phenomenon many continue to revert back to conceptual articles on countertransference (subjective or objective) rather than empirical

research such as the work of Rizq (2005), Geltner (2006), Shafranske and Falender (2008), Hinshelwood (2012) and Waska (2013).

Aims of the current Study

The reviewed literature above showed that there are two major types of countertransference, the subjective and objective. However, these limited studies only focused on the definition of these concepts, but failed to explain the internal processes accompanying these two states of countertransference. The current study seeks to fill the gaps in literature by breaking countertransference down into both subjective and objective areas and empirically research their individual internal processes, investigating what actually occurs within these separate states rather than focus on the definition of countertransference. This study is aiming to understand subjective and objective countertransference specifically from practitioners who are Counselling Psychologists; sticking with the notion that they utilise one of their orientations (the psychodynamic intervention still held within a humanistic framework). As the literature reflects the evoked-emotional content needs largely clarifying from the psychodynamic perspective (as countertransference comes from the school of psychoanalytic domain) and not the cognitive-affective approach of countertransference currently sought by Cognitive Therapists' for example Leahy (2007). As underpinned by the literature; this research aims to explore how reflective practitioners would benefit understanding their own subjective perceptual management investigated by Hayes, Riker & Ingram (1997); Williams (1997), Rossberg, Karteruda, Pedersenc and Friisa (2010), explore the working alliance mentioned by Tishby & Vered, (2011); Rosenburger and Hayes (2002) and the impact countertransference has on the therapeutic process (Hayes, McCracken, McClanahan, Hill, Harp and Carozzoni (1998), Gelso, Latts, Gomez and Fassinger (2002). There also seems to be limited research papers shedding light on these specific populations (Counselling Psychologists) their phenomenological subjective/objective experiences when it comes to countertransference and the reflective/clinical practice of their work surrounding it. Not to mention the reviewed literature lends support to suggest that there is also limited scope of qualitative methodology being used, especially the use of interpretative phenomenological

analysis (IPA), which this study therefore aims to address. Ultimately, This research had two aims, firstly to explore counselling psychologists' experiences of subjective and objective countertransference and secondly, how this impacts the therapeutic process. The question under investigation centres on 'how subjective or objective countertransference becomes manageable in the moment of experiencing it' and 'how this impacts upon the development/maintenance of the therapeutic relationship for counselling psychologists'?

To conclude, this study seeks to fill the gaps and build bridges in the literature by moving away from the vast majority of *conceptual/theoretical* papers but rather engage with more *empirical* findings. As Slater (2007), Betan, Heim, Conklin and Westen (2005), Dahl, Rossberg, Bogwald, Gabbard and Hoglend (2012) would point out, a great deal of rich theoretical work is published and rapidly expanding regarding countertransference, yet there is a dearth of empirical research as it is still conspicuous by its absence in the field of counselling and psychotherapy.

Empirical Research

Method

This section will outline the rationale behind why the methodology was chosen with its' theoretical underpinnings, epistemological aspects and will describe the recruitment process, interview development, analysis of data and a critical discussion around the research quality as a whole.

Approach

The Research design and methodology that was used for this study was a qualitative approach, more specifically Interpretative Phenomenological Analysis (IPA). The theory behind the IPA method stands at it being a relatively new approach coined by the principle developer of IPA Jonathan Smith (1996) in the world of health psychology. Currently having moved beyond the home base of health psychology, IPA is widely applied as a qualitative psychological tool for many emerging from other disciplines and orientations such as the school of counselling, clinical, social and educational institutions (Wagstaff, Jeong, Nolan, Wilson, Tweedlie, Phillips, Senu & Holland, 2014). Firstly, to understand this concept we must consider why IPA has been established and secondly, how it is applied to research. As Smith (1996) argues psychology should not only be experimental, but also experiential (subjective in experience) in a qualitative manner giving insight to individual personal accounts and made it his duty to create this different yet ground breaking method. He predominantly drew his ideas from theoretical philosophical formations that were based around phenomenology, hermeneutics and idiography. This was to inform its distinctive epistemological framework among mainstream psychology, yet still be a part of and contribute to the world of psychology. Examining lived experiences, capturing them for future development, as well as understanding how meanings are constructed through symbolic interactionism was why this method was introduced in the first instance.

Consequently, IPA is very much concerned with the individuals subjective experience and

what this experience in general holds for the individual experiencing it. According to Osborne (1990) past therapists conducting research were convinced that pursuing the quantitative method would be far more credible for others to take seriously, however stressed the idea that those engaging in therapeutic practice are not statisticians but are descriptive beings in their practice and measurement. Based on the findings of Elliot and Zucconi (2006), it can be argued that employing a qualitatively bottom-up strategy gives the therapist researching a far greater scope of easily becoming a pluralist in their own clinical work, giving greater understanding to practice-based evidences. Similarly, Mcleod (2002) cited in Elliot, Lowenthal and Greenburg (2007) stated that psychotherapy sessions themselves can be considered as a piece of research for example dissected information given can be pieced together to formulate understanding, followed by testing the soundness and actions found on mutual knowing.

Theoretical underpinnings

Phenomenology Philosophy

The reasons for selecting IPA as Lyons & Coyle (2007) would point out "…is to explore in detail individual personal and lived experience and to examine how participants are making sense of their personal and social world…IPA has a theoretical commitment to the person as a cognitive, linguistic, affective and physical being…" (p 35/36). Digging a little deeper and breaking down these theoretical aspects further. The philosopher Edmund Husserl (1859-1938) who created phenomenology philosophy proposed that in order to capture everyday experiences he introduced the concept of '*phenomenological attitude'* where by methodical steps are formed leading back to experiences in a reflective way. As it is very hard to comprehend the '*natural attitude'* (as he calls it), where by one can get actively immersed so quickly that it is hard to pin point what occurred from what and perhaps important bits of information can be taken for granted or left out. Whereas the *phenomenological attitude'* moreover, can be once again immersed, but in a different way; a more reflective, consciously engaged way paying close attention to all parts of the experience (phenomena). Husserl rooted his life's work on establishing phenomenology,

focusing on the individuals' perceptual experience in a reflective, attentive and naturalistic way; it is clear that phenomenology philosophy examines what essentially *belongs* to each person personally and introspectively. In addition, participants that provide information of their experience allow researchers to access their own attempted understanding of their understanding (Smith, 1996). Here is where researchers not only understand their own unique experience, but also allow room for the exploration of others to reflect on their significant experiences. Essentially phenomenology philosophy is the study of experience and for psychologists this provides a rich source of ideas about how to examine, inquire and comprehend lived human experiences (Smith, Flowers & Larkin, 2009).

This said, investigating a particular phenomenon lived by a person and highlighting their inner understandings/interpretations within their frame of reference can allow investigators to shed light on homogeneity and "…examine convergence and divergence in some detail…" (Smith, Flowers & Larkin, 2009; p3) The concept that we all have ways and means of dealing with life experiences' makes it rather more fascinating when research places a spot light on these collective complexities as their intricate underpinnings guides the mysteries of research. Although categorically we maybe seen as the same, IPA reminds us of individual differences, that being aware of experience is significant to being reflective (Smith, Flowers & Larkin, 2009). Experiences' therefore help shape our lives in many ways and practitioners relate to the understanding that parts of a person are eventually made of a whole.

Researchers therefore admittedly want to explore these separated identities and bring forth the *common meaning* (Smith, 2007) individuals have as individuals. Overall, "IPA research is hearing the voices of participants from across the sociocultural spectrum" (Reid, Flowers & Larkin, 2005; p 20) consequently acknowledging that IPA's epistemological position comes first and foremost from philosophical individualism.

Hermeneutic Philosophy

Phenomenology is theoretical and perhaps very abstract where by "this method cannot grasp the organic unity of the meaning that makes human phenomena exactly "human"

(Tada, 2013; p 364). Others such as Martin Heidegger (1889-1976) introduced groundbreaking philosophy in which he stated that our comprehensible organised perceptions (owned by us) can become more than the perception of the phenomena (the being-present) (Pontuso, 2014) leading us to new experiences for interpretation. Here is where hermeneutic philosophy (interpretation of understanding) is vastly acknowledged in IPA often involving the "restoration of meaning" (Ricoeur, 1970; p 8) by looking for interpretations hidden in the human experience. What therefore makes' this hermeneutic philosophical direction different yet relevant is the beginnings of the existential emphasis in phenomenological philosophy, the deliberate focus of integrating the worldliness or *person-in-context* perspective rather than just the person (Smith, Flowers & Larkin, 2009; Ashworth, 2003; Molbak, 2012). That a person is inter-subjective in their engagement of the world which gives us dimensions for shared or overlapping interpretations. Therefore this hidden interpretation engages with the Greek term *alethia* meaning *uncovering, revealing* which is an exposing form of seeking the *truth* through our presence in the world (Shinebourne, 2011; Smith, Flowers & Larkin, 2009). Taking this a step further Merleau-Ponty (1962) recognized the individual experience (phenomenology), the bigger context that 'being in the world' affects experience and existence (hermeneutic philosophy) but developed the in-between idea that our relationship to the world has led us to having our own individual situated perspective which he coined *phenomenology of perception* (Merleau-Ponty, 1962).

Hermeneutics

Given the above, the second major theoretical underpinning of IPA is the theory of interpretation, hermeneutics. The particular nature of hermeneutics is to highlight the purpose and methods of the interpretation. Theologian Friedrich Schleiermacher (1768-1834) who attempted to concern himself with removing any preventive restrictions to understanding or analyzing text expanded this idea. Likewise, other hermeneutic philosophers such as Martin Heidegger (1889-1976), Hans- Georg Gadamer (1900-2002) and Paul Ricoeur (1913-2005) further adopted interpretative phenomenology to understand not only the text (the words used) but also the writer. Hermeneutics is different because the researchers bring their own understanding and experience to the research process (Roberts,

2013), the researcher seeks to understand what it means for the participants and therefore attaching further meaning to the experience for them (Smith and Osborne, 2003). As Naden (2010) suggest researchers are actively embarking in important authentic participation during this process. Hermeneutical attitude involve observations, reflections and interpretations not only in the encounter of the researcher-participant interaction, but also the stored memory of this encounter later for retrieval. Translating this memory brings about IPA's fundamental point that we are experientially bringing about the *situation* and the *particular* `to broader aspects such as universal shared experiences for experimental research. For that reason, Smith et al. (2009) concludes "without the phenomenology there would be nothing to interpret; without the hermeneutics the phenomenon would not be seen" (p 37).

Idiographic Mode

Where as the idiographic focus of IPA is then called to explore the uniqueness of an individual, their unique life history, and the unique sequence of events making up who they are as expressed by Cohen, Manion and Morrison, 2007; Eatough and Smith, 2008; Smith, Flowers and Larkin, 2009; Smith, Harré and Van Langenhove, 1995. With this said it raises the idea that the distinctive experiences of the particular person are examined as well as the particular contexts in which those experiences occur. As a researcher the attempts to find out as much as possible of one individual before moving on the next (known as bracketing) is called into practice for fairness and sensitivity. It is only then cross-case analysis can be conducted at its final stages to illustrate general themes of the particular experience and consequently this rich detailed approach complies with small samples giving room for in-depth analysis.

Researchers' Epistemological position

Reflexivity within IPA is also a crucial part of research inquiry as it involves parts of the researchers' self or selves in order to fully understand, appreciate and actively explore their participants phenomena. Equally the researcher trying to gain access to such a phenomenon must in part have some form of conceptualisation with the presented

components (for exploration) so that it is relatable and interpretable, yet remains objective and unbiased with her judgments, being careful not to influence the participants world view or belief (Mearnes & Thorne, 2000; 2007). This idea of phenomenology operates in the unique sandwich understanding that our social interactions or engagements with others, causes an inner function to perceptually make meaning; having an overall inter-subjective experience to the outside world (Smith and Osborn, 2004). Not to mention analysing the data (or inter-subjective experience) and making sense of it may lead to double hermeneutic (Habermas, 1984) within this type of methodology (making sense of the researchers own interpretations about the participants experiences). However, the researchers ontological positioning merely represents her understanding of reality and can interpret through her own experiences and the social context that she lives in by being as impartial, open and fair as possible with each participant (Cohen et al. 2011). The importance of knowing that IPA concerns itself with lived experiences and capturing data in a retrospective and reflective manner enables the phenomenon to thus belong solely to the participant in the first instance and so the researcher carefully uses semi-structured interview questions to gain a more intimate one to one approach not only with the participant but also with the phenomena or phenomenon being explored.

In conclusion, IPA seemingly shares some similarities with differing qualitative methods such as grounded theory through its systematic analysis of text (Willig, 2008), intellectual connections with narrative analysis (Crossely, 2007) and perhaps even the discursive approaches focusing on language and social constructionism (Reicher, 2000). They therefore independently stand alone due to their unique philosophical and ontological roots. IPA was therefore chosen because this particular qualitative approach very much coincides with being a reflective and integrated counseling psychologist, as the theoretical underpinnings undergoes more than what meets the eye, its philosophy goes beyond surface level interaction and that perspective reflects on parts of a phenomena to eventually see the whole. IPA draws on social cognitive thinking and the knowledge produced will be dependent on the researchers standpoint, but also acknowledge the co-construction between the researcher and participant relationship (Larkin *et al,* 2006); much like the collaborative nature of the therapist and client relationship within the remits of therapy. All

in all the aim of the researcher is to understand "what it is like" to experience particular conditions (Willig, 2001; p 9) and to examine how this personal, lived, participant makes sense of their social context.

Participants

Inclusion/Exclusion criteria

Six Counselling Psychologists (in training or qualified) within the UK were recruited for this study. The study sample size is relatively small to afford the researcher an opportunity to do justice to each case and carry out case-by-case analysis of the individual transcripts. Previous researchers have offered support to the adoption of this process (Lyons & Coyle, 2007). Therefore the inclusion criteria were both male or female participants providing one to one therapy; not only experiencing countertransference, but having an awareness of subjective and objective countertransference within their therapeutic practice. The approaches used by each of the therapist were integrative (psychodynamic, cognitive behavioural therapy CBT and humanistic/person-centred). However for the purpose of this study the researcher specifically asked participants to focus on one specific approach, the psychodynamic orientation. The exclusion criteria were based on not recruiting practitioners who live or practice outside of the UK and those who are psychoanalysts as their way of considering transference and countertransference differ. These two concepts are seen as a treatment modality whereas there is another perspective of conceptualizing countertransference now. More specifically those who uphold pure psychoanalytic orientation hold a classical viewpoint regarding countertransference as opposed to the intersubjective/integrated viewpoint.

Sampling

Once the research proposal was given for ethical approval **(Appendix 1)** it was accepted by the University of Wolverhampton School of Applied Science (SAS) Student Management Board **(Appendix 2).** It is also important to mention the research proposal

was amended and re-submitted for approval through the University of Wolverhampton Behavioural Sciences Ethics Committee (BSEC) (**Appendix 3)** as this was due to the lack of participants coming forward to take part in the study. The researcher found it useful to make small adjustments to extend recruitment to trainees on the Practitioner Doctorate course in years one and three (at the time) at the University of Wolverhampton as they were both seen to be unbiased cohorts. Following this, the Board of Ethics known as the University of Wolverhampton Behavioural Sciences Ethics Committee (BSEC) gave an official approval in which the research could be conducted (**Appendix 4)**.

Interview Development

Pilot study

Four Doctoral Counselling Psychology students (from the University of Wolverhampton) participated at the piloting stage of this study. This piloting phase was undertaken to aid the preparation of interview questions and provide insight to how the data collection and the procedure would be structured. This was to examine whether participants/interviewees would understand the instructions given for example, the information sheet (if too much information was given or not enough), if the questions being asked were comprehensible or needed tweaking and to ascertain how much time it will take to conduct an interview.

The pilot study was also useful for the researcher to gain experience as an interviewer and ensure clarity and understanding of the interview protocols well as to examine potential problems and revise the structure to ensure that the interview process was as effective as possible. Therefore, the following were discovered:

Pilot one:

Participant One: Trainee Counseling Psychologist, Female, 33

The investigator found that the length of time posed a problem. Overall the interview lasted 30 minutes and as Lyons & Coyle (2007) would point out "semi-structured

interviews generally last for an hour or more and can become intense and involved, depending on the particular topic" (p 44). Therefore the original questions seemed to have skimmed the surface of the overall study's question and did not allow room for in depth understanding due to the lack of probing and prompting.

Additionally the researcher noticed that she did not reflect to the participant specifically what she needed by perhaps setting the scene for them, for example, informing participants that the questions would be based around past sessions with one particular client where by the practitioner experienced countertransference and that the interview would also reflectively capture how they felt in the moment.

This overall gave the researcher food for thought on how to problem solve each intricate but delicate part of the interviewing procedure and mentally prompted the researcher to better the process. Questions were also evolved through the review of the literature.

Pilot Two:

Participant Two: Trainee Counseling Psychologist, Female, 35

This participant although answered the questions in a lengthy manner, during the process became concerned about issues related to disclosure, such as, what would the researcher do if participants were willing to take part in the study but became reluctant and hesitant to explore aspects of the process due to certain questions exposing their vulnerabilities.

Consequently, the researcher further re-structured and re-worded the questions. All in all it dawned on the researcher that one had to consider and monitor how the interview would affect the future participants, how questioning may be expressed in other forms (such as their non-verbal behavior) and that the researcher would have to be aware and be prepared (when needed) to take a step back or pursue appropriately (Lyons & Coyle, 2007). The researcher explained the boundaries of anonymity at the start of the interview schedule and distributed a debriefing form at the end. This was employed with the researchers' next participant.

Pilot Three:

Participant Three: Trainee Counseling Psychologist, Female, 48

This participant chose not to answer questions due to what she described as it 'being too emotionally driven', which gave the researcher a better insight into being able to offer the option to opt out if participants felt the need to or if the process brings up any unresolved issues that they may be facing. To further this, participants had the right to withdraw at anytime, which is in keeping with the *British Psychological Society's* (BPS) Code of Ethics and Conduct (2009*),* Professional Practice Guidelines (2009) and Generic Professional Practice Guidelines (2008) as well as the Health and Care Professions Council (HCPC) Standards of Conduct, Performance and Ethics, (2009) & Standards of Proficiency: Practitioner Psychologists (2010)

By now the researcher felt that the revised questions and the amended interview schedule **(Appendix 5)** following board approval, were prompts to making this process an exciting, safe, ethical, rigorous and powerful one.

Data Collection Procedure

Recruitment

Advertising for recruitment involved approaching a plethora of Academic institutions, as well as displaying recruitment information **(appendix 6**) via the Division of Counselling Psychology Discussion forum on the British Psychological Society online site. Other outlets were social media sites such as the North West Branch of the BPS Division of Counselling Psychology's Facebook page and their newsletter bulletin/e-news flash weekly. This study adopted a purposive sampling method to recruit participants. This is because the study focused upon recruiting only the practitioners who have experienced countertransference in a one-to-one therapeutic setting in the past. Nonetheless emailing existing practitioners from the BPS Directory helped snow ball the process quite quickly.

Interview Procedure

Six volunteers took part in this main study and although by professional training they are deemed integrative counselling psychologists' (as asked throughout the interview process). Utilising the Psychodynamic, CBT and Humanistic/person-centred approaches, these participants often felt it mandatory to use specified interventions based on their contextual job posts as seen in Table 1 below. But for this study they were asked to focus on one past client with the knowledge of them using the psychodynamic approach (where countertransference comes from) to help answer questions throughout the interview process. Therefore the participants were familiar with the concept of countertransference prior to taking part in this study because it was explained to them within the researchers recruitment advert (see appendix 6) and the participant information sheet (see appendix 7) that they only apply if they already knew of, worked with and had a personal perspective on countertransference. Lastly, throughout the interview schedule the participants were asked what countertransference meant to them, and what specific orientation they used within their clinical practice. This therefore may have influenced the richness of the data produced as some participants may have had more training, reading and practice concerning both transference and countertransference.

It is worth noting that the majority of participants within this gathered data are more females than males having a ratio of 5:1 (see table 1). This is a direct representation of the profession as Seager and Wilkins (2014) reports less than a quarter of psychology graduates are men and 80% of those that provide psychological services are women (Morison, Trigeorgis and John, 2014). Previous statistics from the British Psychological Society, (2004) also revealed that only 22 per cent of men applied through Universities and Colleges Admissions Service (UCAS) to study psychology undergraduate courses. Other expressive concerns such as Bradley, (2013) and the Department of Health (2002) suggest that males are less likely to apply to training courses such as counselling or psychology as it is seen as 'female led' or 'feminised'.

All participants however were contacted to discuss the study in depth whereby they were given an information sheet regarding the aims of the study and the research procedure **(Appendix 7)**. Once collaborative agreements to partake in the study had taken place, a formal interview date was arranged with information provided to the participant including time slot and duration. A confidential space/setting suiting both parties was utilised for the interview and prior to interview an informed consent form with the right to withdraw was given **(See Appendix 8)**

Table 1: Participant's information

Participant Pseudonym	**Gender**	**Clinical or Counselling Psychologist**	Interventions used by the therapist	**No. of years of experience**	**Qualified / Trainee**
WF	Female	Counselling	Mainly CBT or Psychodynamic	10 +	Qualified
PM	Male	Counselling	Mainly integrative	6 +	Qualified
JP	Female	Counselling	Mainly Humanistic	3	Trainee
FF	Female	Counselling	Mainly integrative	3	Trainee
SB	Female	Counselling	Mainly Humanistic but integrative.	8 +	Qualified
SC	Female	Counselling	Mainly Psychodynamic	10 +	Qualified

Ethical Considerations

Participants were given a consent form to read and sign. The main purpose of this informed consent process was to protect the participant. It therefore explained that by undertaking the study they would be giving consent to participate and that intentional deception would not take place.

Participants were well informed of their right to withdraw before, during or up until the commencement of the data analysis (July 2014). This was to provide respect and autonomy for the participants. The participants were also reassured of the confidentiality of data collected and the fact that their responses will be anonymized such that no one will trace the data to them personally. This is in line with the BPS (2009) *Code of Ethics and Conduct* regarding respect, competence, responsibility and integrity for the protection/safety of the general public, DCOP's *Professional Practice Guidelines* (2005) and HCPC, *Guidance on Conduct and Ethics for Students* (2008) as well as *Standards of Conduct, Performance and Ethics* (HCPC, 2009) to ensure ethical procedures to be followed and applied accordingly. Debriefing was also conducted at the end of the interview procedure to ensure that if any discomfort was experienced participants could be sign posted to the relevant outlets such as therapists etc. **(See Appendix 9).**

Furthermore participants were given the option to receive a lay summary of the main findings and were also informed that the researcher will securely keep the raw data for up to five years after the completion of the study. They were also made aware that only supervisors and examiners would have access to the raw data and no identifiable information will appear in the report or in any publication that results from the research.

Additionally, the researcher made use of an audio recorder in order to capture the interviews, which were, later transcribed manually by the researcher to a word document for further data analysis. However immediately after the collection of data, the researchers immediate reactions, thoughts, feelings regarding the process were written down in her reflective journal both gathering her thought process and the encounters of each individual

introspective experience. This would later also help with immersing back into the research relationship retrospectively (Elliot, Lowenthal & Greenwood, 2007).

Data Analysis

The researchers' beliefs about transference and countertransference comes from the understanding and acknowledgment of the training she gained from her university; the university of Wolverhampton. Prior to this, the researcher did not have concrete or substantial knowledge about transference or countertransference. Additionally it was through reading a variety of materials that built such knowledge and through clinical experience (theory to practice) that informed both these areas. The researchers' own belief therefore of transference stems at understanding that each individual client steps into the therapeutic space with their own thoughts, beliefs, their rules of assumptions on life, their early experiences also shaping who they are and how they may react due to environmental circumstance. It is thus up to the therapist to be aware of this and with clinical decision making bring it to the clients' attention within the safety of the therapeutic space. On the other hand as countertransference has three definitional concepts (*the* classic view, totalisitc *and* inter-subjective *perspectives)* the researcher acknowledges all of them (as she works in an integrated manner); yet primarily identifies with the totalisitic perspective. Further to this the researcher distinguishes her internal evoked feelings by understanding what resonates with her more (the subjective understanding) versus what affects her emotionally from a bystander or observational perspective (objectivity). This therefore may have influenced the researchers' analysis due to her knowledge of theory-based evidence and evidence based theory.

The interviews were analysed by using the method of IPA where by the researcher read through each transcript several times whilst listening to the participants' tape recordings and wrote down initial comments, literal or visual descriptions, thoughts, questions and observations to the text (Smith et. al, 1999). The researcher then went over this particular segment again by bracketing off (Husserl1996) any presumptuous reactions (for example jealousy), critical judgements (I wonder if she thinks she is a good enough therapist) or own conscious assumptions (if there was more self care the outcome may have been

different) based on the researchers experiences rather than what the transcript provided. This was done through additional note taking and personal journal writing to have clarity over emergent interpretations. Riley (1990) similarly proposed that getting the most out of your data analysis through coding, making transcripts, linear codes in the margin, coding paragraphs, highlighting texts, adding comments, reading aloud, concentrating on a single sentence, brainstorming, keeping a diary and even engaging in self-interrogation is needed to organize and add value to the under layers of content.

The second stage of analysis required the researcher to label themes for relevant sections of the text (which she analyses') attempting to identify underlying meaning. Therefore the investigator's initial thoughts or interpretations were influenced not only through her own psychodynamic training but also the contemporary works of Professor Wendy Hollway (2000), who provided an intriguing and useful theoretical outlining of a qualitative procedure in her book '*Doing Qualitative Research Differently: Free Association, Narrative and the Interview Method'*. Here Hollway (2000) describes the approach as the *free association narrative interview,* although the current study adopted IPA for the analysis of the data obtained, the concept from Hollways' (2000) theoretical underpinnings was applied and this influenced the analysis. This is in support of Elliot, Lowenthal and Greenwood (2007) who reiterated that the *free association method* provides a basis for critical exploration of clinical material. This is a specific method of interviewing participants but also analysing the narratives obtained by the interview(s). It utilises psychoanalytic theory as well as reflexivity to produce meaning; which implies the importance of deploying the researcher's own subjectivity to assist the analysis.

Hollway (2000) found this theoretical basis to be a psycho-social way of gathering information not only in looking at the gathered data, but also at the participant in depth. Like IPA, open-ended questions need to be used for the flow of narration (during the interview) as well as probing and prompting. However Hollway (2000) recommends note taking during the initial narration to enable follow up questions, which IPA similarly acknowledges. This seemingly biographical-interpretative method supports the concept that their needs to be an exploration of the interviewer and interviewee's research

relationship which is not the focus of IPA but rather a part of hermeneutic interpretation. Taking this into account, Hollway (2000) emphasises that during the analysis of data produced one needs to look at the unconscious material elicited, the defenses (projections), introjections, feelings from the other and the positioning in which the narrative is coming from (transference/countertransference). Both IPA and the *free association method* fit well with the individual framework of the participants (bio-psycho-social phenomena) and consider dual-processing, double hermeneutics and its idiographic context; giving reason to why the *free association method* was applied to the analysis rather than the interview process.

Continuing with the second stage and employing the above processes aided the essential reality of the underlying layers to the participants' phenomena. The third stage required the researcher to group the themes together, which was produced within a table. This method of analysis was respectively done for each participant and further narrowed down into categorical aspects of subjective and objective countertransference by reading and re-reading the emergent themes placing them carefully into these separate columns. Again bracketing off oneself was done to produce congruency to the data. With this continuous method of working, sub-ordinate themes were produced chronologically by way of clustering concepts and searching for connections across emergent themes (Smith, Flowers & Larkin, 2009; Smith, 1999). Through creative *abstraction* and *contextualization* (Smith, Flowers & Larkin, 2009; Smith and Osborn, 2008) super-ordinate themes were made whilst looking for patterns across sub-ordinate themes. As IPA looks at the idiographic concept (looking at the parts that make up a whole), at this stage the micro-analysis (emergent themes, sub/super ordinate themes) goes back to the whole (the transcript) for deeper levels of interpretation by using quotes/passages to distinctively connect with the phenomena being explored which is expressed within the results below (Willig, 2008; p 58).

Results

As mentioned in the method section, IPA was adopted for data analysis in this study. The emergent themes were based on the participants' reports of the subjective and objective countertransference experience as they work as therapists and how this affects their therapeutic relationship, as well as how they manage it **(See Appendix 10-16).**

All therapists experienced most of the subjective and objective themes listed below and thus the reader will see overlaps of direct quotes from participants, which are written in italics in various sections.

Seven super-ordinate themes were developed from the data as follows:

- Professional
- Personal
- Reactors
- Clients life outside the Analysis
- Service Restrictions
- Therapeutic Relationship
- Training

Table 2: 'Subjective' Super-ordinate and Subordinate themes

Super-ordinate	**Sub-ordinate themes**
Professional	• Interpretation through Awareness • Logistics over feelings • Techniques
Personal	• Humanistic Self
Reactors	• Immediacy of Self

Table 3: 'Objective' Super-ordinate and Subordinate themes

Super-ordinate	Sub-ordinate themes
Clients life experiences	• Primary level (All that belongs to the client) • Secondary Level (Further information received from the client)

Table 4: 'Contributing Factors to Countertransference' Super-ordinate and Subordinate themes

Super-ordinate	Sub-ordinate themes
Service Restrictions	• Internal Pressures • External Pressures
Therapeutic Relationship	• Readiness for Relational Depth • Debris of CT
Training	• Preparations

‘Subjective’ Super-ordinate and Subordinate themes

1. Professional (subjective super-ordinate theme)

Three distinctive sub-ordinate themes (*interpretation through awareness, Logistics over feelings and Techniques)* were grouped together producing the super-ordinate theme known as the *Professional*. Therefore during the experience of subjective countertransference it was revealed that the first subjective super-ordinate theme developed/revealed was the *Professional* part. The sub-ordinate themes listed below captures in depth the micro-analysis of the clients’ transcript as a whole using specified quotations to assist the final produced super-ordinate theme.

Interpretation through Awareness (subjective sub-ordinate theme)

All participants were aware of having *interpretation through awareness,* by this one means things that needed to be done within the therapeutic relationship to help the client. For example practicing ethical and moral obligations to assist the client and finding rational, calm and methodical ways of responding to the needs presented. Areas such as having a sequence to work by, problem solving through solution-focused approaches, being reflective, recognising and using containment, having boundaries, coping strategies/techniques and having logical awareness over feelings. The subjective-professional side is often seen as an authoritative presence that is readily available to stop, think, analyse then react or respond to their clients’ needs within any given context or moment.

In contrast, being fully *aware* of the transference or countertransference reactions, one can interpret the narratives to employ interventional needs. All participants felt that their judgments were better with a clearer distinction of what belonged to whom within the therapeutic space and were able to aid the process rather than hinder it. Additionally

interpretations through awareness remotely gave helpful insight to managing countertransference and thus how it can be used as expressed by some of the participants below

"I think it depends on how you use it... I think if you don't pay attention to the countertransference that you experience when your with the client then it can be quite damaging, because I think your missing something; because a big part of therapy your missing if you're not paying attention to what's happening with you and a client." (PM, 455-459; P11)

PM continues to point out how his great sense of awareness with what the client gives him and how he receives it can have an impact on his sense of self. For example he comments "*…sometimes I think countertransference for me is that bit about paying attention to my own reactions to a client that I have and I'm wondering what that's about for me? So is it that I'm reacting in a way that I might not react with other clients and why am I reacting in this way with this client?"(Lines, 72-75; P2)*

There seems to be a running theme amongst the participants that awareness is vitally important to move the self, relationship and the process forward *SB,* concurs by stating; *"I think I've got a good awareness of my own reactions; so when I'm kind of reacting in a way that I wouldn't expect me to react, then I kind of assume that's something that the client is soliciting within me" (lines, 69-71; P2).* Whereas *WF* confirms that for her *"its almost a sense where I have to; stop that flight/fight response where I kind of have to take deep breaths and don't let myself get in that panic and I can manage this and I can control it" (lines, 107-109; P3)*

Logistics Over Feelings (subjective sub-ordinate theme)

Staying with the under-layers of the *Professional* super-ordinate theme*,* many found that the power of ones' own unresolved conflict were often pushed aside to avoid emotional entanglement with the client (hence the subjective sub-ordinate theme *logistics over feelings*). In the moments of experiencing this type of subjective countertransference participants merely accepted that their unresolved 'stuff' exists, but allowing their selves to

move forward in using integrative interventions to aid their clients was what needed to be done. Participants often encouraged self-management by identifying that they have to remain professional and logical as they do their job.

As an example participant *SB* found herself slowly integrating her unresolved feelings with her then client and found that it was hard not to react or respond to her own subjective experience. With that, *SB* quickly found solutions beneficial for her client rather than her own needs in a practical manner:

"I think I went into solution finding, I wanted to get something concrete that I could give her, I wanted to find… a way of showing her that I was doing something... I needed to feel like I'd kind of ticked a box for kind of risk management here, I needed to feel like I was giving her something that could kind of boundary her distress… so…kind of went into trying to fix, trying to find a way of making it all ok in a very practical way" (SB, 79-85; P2)

Knowing that there are also different parts of the cognitive/affective process' that may dominate the situation and overshadow your clients progression are the parts one can also serve to manage as clearly pointed out by *PM* and *FF* below

"…I think there were times when erm because of, in a way the narrative that she was sharing; there was a bit of occasionally I'd be mindful of this 'don't slip into this' but try to protect and look after her" (PM, 383-385; P9) as well as "I think the one thing I told myself errr was to 'ok get rid of it whatever thoughts get rid of it cause there getting in ya way' back to empathy, back to being with the client…" (FF, 214-216; P6)

Additionally the fine line between personal reactors and professional logistics are seemingly interconnected, but there is a cognitive awareness which can be emotionally/affectively contained as *SC* claims;

"When you're being provoked its quite hard not to respond isn't it? In everyday life and in the therapeutic situation when you're being provoked (pauses) you still feel aware that you'd like to be retaliatory I suppose but you can't be can you and your job is to think about what is being evoked in me and what this is about and what does it mean?" (lines,

82-85; P3)

Techniques (subjective sub-ordinate theme)

Lastly, there is a strong essential understanding amongst the participants beliefs' that by having preconceived techniques before you enter the domain of a therapeutic engagement will help one cope during the likes of projection, projection identification, erotic attraction, transference and so forth. This may interfere with the subjective-professional part of countertransference in the captured moments of experiencing it. These are "*self-talk*" (*WF*, 139; p 4), "*internal dialogue*" (*PM*, 229; p6) to help one anchor him/herself whilst "*shifting cognitively*" (*PM*, 230; p6), having "*self-awareness*" (*SB*, 230 p6)"*noticing the impact it's having on you*" (*JP*, 273 p7), equally use "*mindfulness…grounding…breath control… and the core conditions*" (*FF*, 211 p6) to get back with the client in their moment of expression or vulnerable exposure. Not to mention seeking out your "*internal barometer*" (*SB*, 232, P6) or "*internal supervisor*" (*PM*, 212 p5) as *PM* elaborates *"what helped me in this situation was to kind of just take a moment and often what I find myself doing is I might just reposition my seat or how I sit that kind of just shifts my body posture helps me to have that internal check in with my internal supervisor"* (*PM*, 223-226; p5/6). Consequently it is *"…[to] be able to say I didn't feel this before I came into the room and I'm feeling it now, so it's something to do with the in between" (SC, 343/4; p 8).* Overall techniques help cater for blind spots that are presented or confronted when there are moments of experiencing an encounter for the first time.

To round off *interpretation through awareness, logistics over feelings and Techniques* are all fused together to make up one part of the subjective countertransference known as the *Professional* (as labeled above).

2. Personal (subjective super-ordinate theme)

The second subjective super-ordinate theme developed from the data is the *Personal* part representing one distinctive sub-ordinate theme the *Humanistic self.* This is another component of the experience of subjective countertransference. Within this line of work the possibility that we leave our selves at the door and pick them back up on the way out

was widely acknowledged to be untrue. Here the personal-subjective aspect remotely shapes the many countertransference definitions that scholars have debated over for years. This includes participants acknowledging their *unresolved conflicts* (Freudian concept), to the *Totalistic* and *inter-subjective/relational* concepts. As highlighted by *SB* "*I don't believe that I'm a blank slate"* (line 66-67; p 2) and continues by expressing "*I obviously come in with my own stuff erm so I'm aware of that*" (line 68; p 2).

***Humanistic Self* (**subjective sub-ordinate theme)

Unanimously all participants agreed that their true selves could never escape them and with the ontological idea of *just being*, realistic assumptions were present. This was the overall middle ground that responded to meeting human needs naturally. The context of the personal-subjective self within this frame encapsulated the therapists to be often vulnerable meeting their own needs purely for self-preservation. Many at times doubted their skills and abilities, became self- critical, would not self-disclose and became a cautionary adult; however finding a way to simultaneously protect and rescue their clients. For example liberation through congruency *JP* presents:

"*I think once it was out there she was kind of taken aback I think she… kind of stopped in her tracks almost… cause the focus was on me and I was saying how I was feeling an perhaps this [was] a reflection of…her experiences at work or how possibly other staff members [were] feeling I think, it just gave her that perspective of 'ok what is this about?*" *(lines*, 262-266; P 7).

Likewise the occurrence of 'stuck feelings' and humanly responding in particular situations also came across for example *"I'm bounced around the room and I don't know how to manage this and I don't know what to do and it does make you feel very very deskilled* (*WF,* 111-112; P3). As well as compared to participant *FF* who describes in detail that she had lots of thoughts that actually went onto her panicking *"[my] mind just went blank and all I could hear myself saying was 'shit, shit shit' over and over and…then my mind was saying 'this really isn't gonna help you in the session now'…'say something', 'address it', ' say it', 'address it' and I was thinking what am I addressing?"* (Lines, 107-110; P3)

On the other hand feeling a sense of burden to self-disclose due to parallel processing or perhaps experiencing vicarious trauma had *PM* disconnect emotionally (enduring in arm length sympathy) and re-connect with himself empathetically:

"I got that kind of sense of in a way when she spoke about her pain and her loss I could resonate with 'yes I could hear her pain and her loss', but also I could feel a different part of me which was connected with my pain and my loss." (*Lines*, 118-121; P3)

3. Reactors (subjective super-ordinate theme)

Lastly, the third subjective super-ordinate theme developed is called the *Reactors*. Nearly all of the participants also recognised that at times they reacted with immediacy. The reactions maybe experienced and not shared with the client but equally spontaneously wanting to respond and not being able to (remembering they are in a professional context), caused an under-layer to the therapeutic relationship. The research participants was using the therapeutic space for their own needs (not necessarily making it the focal point of the sessions) but acknowledged it was present. For example taking no ownership, being selfish, rescuing his/her self, holding therapeutic power and avoiding self-disclosure to aid the client were all experienced. For example *JP* relays when talking of her client "*I just wanted to switch off [as I was] feeling quite annoyed with her"* (*JP*, 140; P 4)

Immediacy of self (subjective sub-ordinate theme)

This part showed the participants that it was an area of themselves that did not always want to stop and think, then process a problem but instinctually it occurred. For example *FF* reports *"my mind was saying to me 'yeah you need to address it' so my mind is instinctually knowing I need to go forward and address this issue."* (144-146; P 4) *PM* discloses "*I could feel a different part of me which was connected with my pain and my loss."* (*Lines*, 120-121; P3) and *SB* recalls "*there is a natural rescuer part of me"* (92; P3), which can be reactive at times for her.

PM points out the resistance and hesitance of noticing that his immediacy engulfed his internal world and quickly rescued his self (thinking beyond the moment) not to therefore

weigh his client down. He states *"I think I would have been preoccupied then with 'what she gonna go away with?'...have I burdened her with my own way now, my own stuff"* (lines, 316-317/321; P8) so *PM* immediately chose not to self-disclose to protect himself due to what it seems like his own painful unresolved experience. Where by he admits *"I was caught up subjectively thinking about what I was trying to do with my wife at the time an trying to kind of help and support her, an do what I could an how [her husband had] missed that I think"* (*PM*, 122-124; P3). Here we see *PM* immediately comparing his life to his clients' partner as they both were in the same position of supporting their spouses. It is clear that *PM* did not rescue the client when he could have; immediately withdrew to protect his self as the situation was too close to home to explore. *PM* even recognises this by expressing *"I guess for me there was a bit about 'I wasn't sharing' that in that moment so a bit of kind of me holding that back a little bit"* (*PM*, 293-295; P7)

JP also recalls that her immediate reaction in a given moment also perpetuated a cycle with her client with other forthcoming sessions, she explains *"I was thinking 'I can't wait to get out this session" (115; P 3)* but overall found that this immediate reaction caused a chain reaction on the maintenance of the working alliance; *"I think I'd find myself always kind of not looking forward to those sessions when it comes to that week and then erm within those sessions I'd feel really kind of physically tired, mentally drained…"* (*lines,* 131-133' p 4)

It is clear from this data that, subjective countertransference is made up of three distinctive elements; that is the *Professional*, *Personal* and the *Reactors.*

'Objective' Super-ordinate and Subordinate themes

4. Clients' life experiences (objective super-ordinate theme)

It is safe to say that objective countertransference is relatively having a full awareness of evoked responses towards the clients but knowing that ultimately the transferences belong to the client. There is a fine line between the therapists' 'stuff' and the clients 'stuff' as

there is no telling point to where the therapists' 'stuff' begins/ends nor the clients. This can often be a difficult transitional cycle to differentiate. However the main findings indicate that objective countertransference has two parts a *primary level*; all that belongs to the client such as resistance and defenses and the *secondary level***;** further information received in from the client such as empathy and containing the clients responses. This inevitably changes the mood, context, content of the presenting issue and how best to move forward with new insight.

Primary Level *(all that belongs to the client)*- (objective sub-ordinate theme)

The Primary Level refers to everything that the client owns in the therapeutic relationship; primarily things that live outside of the analysis that is brought into the room such as projection, projective identification and readiness of client which are explored below.

Research participants reflected that clients would give them defenses mainly to avoid confronting their pertinent issues. *FF* found that experiencing the clients' negative/erotic transference lead to uncomfortable congruence*"...next session erm it came up about something about him taking me to a hotel room again I said 'I'm just gonna stop you there and erm ' and I said something like 'I really feel from this session and our last session that actually that your flirting with me?' so a lot of flirting going on"* (*FF*, 278-281; p 7). As well as realising cognitively what is going on and connecting with it at a recusing arms length, as indicated by *SB* "[*I had*] *to kind of pull myself back and kind of give her…that space and then I can kind of be here and listen to it, but I'm not gonna jump in and kind of drown with [her]…"* (133-135; p 3)

WF went on to suggest that there is a clear distinction between transference and countertransference for her. Yet knowingly sees that her reaction is based within countertransference but does not clarify whether she is reacting to subjective or objective countertransference or a mixture of both, *"...I guess, that is probably the transference, that's, that's how they feel that's that's what their passing over because they don't know, they cant make sense of the world, so they're making me feel like I cant make sense of what, what needs to happen to help them and the countertransference is I'm angry because*

*I don't know what to do" (lines,*112-116; P3)

Participants understood at times how their clients were manipulating the process and their feelings, but often utilised this to benefit the clients by eventually bringing aspects of it to the clients awareness. *FF* recalls being powerfully manipulated by her client which led to her being distracted, caught up in her own subjective experience, but understood the clients defense of avoidance so that he did not "… *have to talk about what it is that brings him there, he doesn't have to get into his stuff because I'm so busy in my own world so if he keeps me busy in my world then I'm not going to join him in his world",* (*FF*, 249-251 p 6)

WF concurs that her experience of trying to understand her own emotions after it being forced onto by her client, she had to spin the client's manipulation around by addressing the meaning of what she was doing and how to use it to aid the client, " *obviously sensing it wasn't nice… it demonstrates how other people perceive her erm and that's how in her everyday walk of life that's how people perceive her and maybe give an indication or give some idea of why she doesn't manage in social circles… so in that way it is positive, because then you can do some work on helping her in social skills and social ways…"* (160-165; P4)

The state of being fully prepared to accept, trust, be vulnerable or have the willingness to allow the unknown into ones' awareness was also difficult for clients to comprehend as the research participants exclaims *"Maybe there was erotic transference cause he wasn't sure if he could trust me erm but I think we hit on a defense head on and it was only until we kind of worked with that, that we could kind of never come down, his defense mechanism, his barrier never came down, but he'd pull it down just enough for me to enter his world…"*(*FF*, 303-307 p 8). *SC* also finds that what she *"…might do depends really on the needs of the client and what I felt was going to be helpful and what I feel could be heard…*" (*Lines*, 20/21; p1) As sometimes what is expressed to the client may just sit with them, but not really resonate cognitively, emotionally or even behaviorally. Other times it is brought into their awareness and accepting it may cause defenses due to their bigger contextual unique circumstances leading up to their current position. Like *PM* points out it is looking at their *"…earlier relationships that they've had as a …young child…"* (Line

67, p 2) Timing therefore is everything on what the client wants to hear, take on board and actively integrate into their world. With this point *WF* recalls her clients unwillingness to be ready caused an escalation whereby she had to "*threaten to hit the panic button because it's got violent*" (line 121, p3)

Secondary Level (further information received from the client) –(objective sub-ordinate theme)

Further information received in from the client refers to all that belongs to the client having an effect on the therapist, by eventually leading its way back to the subjective self (super-ordinate Professional, Personal and Reactors). For example with any given contextual framework experienced from the participant in the therapeutic relationship; whilst they try and make sense of their clients transference (having an effect on them) and understanding their own positioning of making sense of both unique worlds; participants expressed a commonality of their subjective parts (as highlighted above) still becoming impacted. For example *WF* immediately felt hesitant to continue giving therapy due to her physiological body letting her become aware of the immediate cognitive reaction she was experiencing in her given situation. She gives an example below

"*…the physiological is, I kind of have a little bit of a 'do I stay and fight this out or do I run because I don't know what to do'….*" (*WF*, 117-118; p 3) This seems like her personal immediate subjective self was affected by the clients' unique situation, which may have mirrored her own idiographic circumstance.

Other transferences from the participants' client led to a lack of room for manoeuver where *FF* especially felt like she was *"…coming down with the emotion of being quite fearful in the room*" (*FF*, 80; p 2) and was unsure where the fear was coming from and where to go with it. Perhaps a blind spot here occurred which both the objective countertransference seemingly became the subjective countertransference changing the narrative and the working alliance. Here we see it happens again below where although we state there are distinctive categories of the subjective and objective areas; for example *SC* states "*I think probably [I was] feeling quite irritated, annoyed with the client at that time*" (63; P2) or *SB* claiming "*I think…in that moment I was feeling a real kind of desperation I think a real*

kind of helplessness, a real want to do something different… but I think my overall was kind of anxiety, desperation-ee" (lines 60-62; P2) participants still are influenced by the analysis of the clients' world and *take* or *make* what does not belong to them in a personal manner which tap into their own core beliefs of themselves perhaps.

Again *JP* identifies that the way she was raised which affects her humanistic side, which when faced with her clients' analysis (the way the client was speaking in the therapy room) automatically the situation and experience became about the research participants unresolved conflicts which impacted her sense of being in that moment:

"I think reflecting back… when I was younger it was erm the way I was brought up it was that kind of going into like private school and things; you're always told to slow down… talk kind of in a respectful way…" (lines 95-98; P3)

The participants formed sometimes quite reactive incongruence and judgments towards the client as *SC* exclaims *"she was a client who'd come in with anorexia but she had a double chin but she was quite well padded but she would tell me she only ate a carrot and a sprout a day"* (*SC*, 112-114; P 3) so although it was objective countertransference hermeneutic empathy was not expressed as Heidegger (1889-1976), would suggest and the mask of inauthenticity drops seeing the human being as a human being.

'<u>Contributing Factors to Countertransference' Super-ordinate and Sub-ordinate themes</u>

5. Service Restrictions (contributing factors: super-ordinate theme)

Participants drew their attention to contributory factors that affected both the subjective and objective experience of countertransference and depending on their extremities could have implications. The needs of the service was often put before the needs of the clients and the tools that the participants could use to aid their clients were often limited or

disregarded based on the overall context or environment best suited for the service. This would often lead to other evoked feelings such as *internal pressures* masking in the backdrop within the therapeutic process.

Internal Pressures (contributing factors: sub-ordinate theme)

There is pressure to fix the client instead of working through integration. In such situations specified interventions are often suggested and research participants often experience less freedom to experiment or take risks such as self-disclosure and relational exploration due to service restrictions/requirements.

As expressed by *JP,* she thought the rigidity of having to use specified interventions based on the services expectations of her made it difficult to perform relationship building alliance; "*I think I put pressure on my self to be able to do CBT… especially because of IAPT service its more…structured CBT so kind of agenda setting, it really is quite… difficult at times and I think because of the session lengths as well there's only so much you can do, so if you did want to kind of deviate from the plan say, you really need that time to be able to do that*" (14-20; P1). Having to push aside her integrated skills for the rule of the majority rather than her own way of working. With this structure she felt there was no room to explore due to time restrictions and how much she is allowed to offer.

SB agreed that she felt a lot of pressure to fix her clients, as well as " *come up with a magic answer…*" (lines, 29-32; P1) to ensure they were seen and the outcomes were service friendly. Others felt there is less scope to explore with clients when the environment is unstable such as going through service reformation or change to protocols and therefore has an extended/ knock on affect to the sessions, as demonstrated by *FF* "*I know in the NHS…the services is going through a transformation an even a simple thing like… you can't access triage…influences my work…then makes me feel erm more cautious…more frightened maybe more than I would be if I had that support available*" *(*lines, 26-33; P1)

For that reason it is unanimous that in particular the IAPT service shares the same outward view, hence *PM* concurs that "*…in an IAPT service I guess there's this pressure and demands on seeing clients, outcomes and targets*" (lines 33-35; P1)

External Pressures (contributing factors: sub-ordinate theme)

External pressures seem to be an important focus, as sustaining the service or business is a reflection on research participants' competency levels, their employability stature and if they are good enough to perform in an establishment. This therefore taps into and has an influence on the subjective countertransference (if one is good enough, is skilled, can perform, can be professional and deliver) as well as the objective countertransference where one experiences limited relational depth and has to focus primarily on the diagnosis to meet environmental and service standards. For example *PM* finds that he is paying less attention to his clients needs because of the outward service demands; "*…in an IAPT service where I'm limited to 12 sessions probably maximum with a client, I think I have less scope probably to work with countertransference" (PM, 27-28; P1*) he continues to state *"I have this kind of external kind of pressure on me which is about targets, performance an seeing people"* (*PM*, 49-50; P2).

More importantly it seems to be a competitive demand for hire in the IAPT service, which makes worse for wear on giving all of ones' integrative parts' as the service demandingly needs CBT as expressed by *JP* and *FF* "*My placement at the moment is… in IAPT Service…I think I've chosen that consciously because of…how the government are kind of backing it up so much it'll look good on a cv… but yeah it's taking some adjusting to I think*." (*JP*, 5-11; P1) Likewise, "*In the NHS again because it's an organisation they've got lots of erm rules and regulations that sometimes can leave you feeling erm a bit straint within that an I suppose that strain can influence what your feeling towards the client…*" (*FF*, 23-26 P1.)

Leveraging the ability to mobilise quickly and doing it in a medicalised manner is also felt "*I think because it's a high volume service of clients coming in and out, in and out and there's pressure to kind of erm get people back to work and I don't think there's not much time to explore… I think it's more about kind of what they're coming for? What can we*

help them with?" (*JP*, 47-50; P2). There seems to be a overall goal or agenda that research participants feel they have to work towards and having to change certain processes to better the service and the systems around them rather than the overall goals of the clients. Such as where *SB* feels "…*a lot more kind of under pressure within CAMHS… often with parents and social workers*…" (29-31; P1)

6. Therapeutic Relationship (contributing factors: super-ordinate theme)

This study found that although relational exploration is not the forefront of therapy as previously examined due to internal and external restrictions, there are some powerful moments that still do occur. With regards to, the contributory factors to subjective and objective countertransference lays with the pre-disposition of the readiness of the client to take part in therapy and their commitments for change. The offset would then be the matter of transference where by it affects the countertransference (subjective and objective aspects). The readiness for relational depth by having a trusting relationship, paying close attention, having a connection, attunement, formalising boundaries and ensuing mirroring would shape the maintenance of the relationship not only in the moment of experiencing countertransference but also beyond.

Readiness for Relational Depth (contributing factors sub-ordinate theme)

Here *WF* could see that her relational attunement with her client caused a chain reaction to other significant areas of the clients' life.

"…because I was able to understand her and understand her internal world, she was then able to trust me so because of that trust and that relationship we built together other things that were happening like self harming, she was cutting pretty bad, we were able to work on that which reduced and it eventually stopped erm, other things like promiscuous behaviour that she was doing, and other things like that, that stopped, erm because the trust we had" (*Line*, 214-219; P 6).

PM expresses empathy and attunement although being aware that his subjective and objective countertransference were blurred and mixed as one.

"I think in the moment as we were talking, the pace had slowed an a kind of eye contact had increased and there was a kind of, kind of relational depth to where we were kind of going with this, erm and seeing her pain, you know, yeah she's feeling pain but you could see it" (*PM*, 190-193; P 5)

JP often wonders the means by which the clients' readiness or the therapist's readiness to take on countertransference and use it in a meaningful way to create relational depth: *"I think…how much is this affecting our process our therapeutic process"* (275-277; P7)

Participant *FF* felt she could not be in the 'good enough' role and felt ineffective due to the clients' initially holding some sort of power due to his own issues with trusting and testing others *"the client had the control erm which meant we're not sharing it"* (258; P7); the flexibility to be ready and share the burden, the work to collaboratively move forward, countertransference plays a part to the building blocks of a therapeutic relationship.

Debris of CT (contributing factors: sub-ordinate theme)

Equally the beginnings of a formulated therapeutic relationship (good or challenging) because of subjective and objective countertransference will continue to play a massive role (whether in the moment of experiencing countertransference or the duration of maintaining the relationship over a period of time); by this it is clear that what ever is arisen from countertransference contributory aspects such as decision making, the meetings of unresolved psychological contact (in the here and now), defenses, judgments being hindered due to the mixed nature of both subjective and objective emotions will have a massive impact on managing the relationship and ultimately managing countertransference further along the collaborative process.

SB recognises that at times "*the client is soliciting [something] within me, so I think in this situation I can understand my reaction from myself*" (71-72; P2) and with understanding "*it depends on what it's about, what it brings up for you, how it's going to impact if you do raise it with the client how will they take it, would it be helpful to therapy" (JP,* 340-342; P 8).

This all comes with decision making, being reflective with what countertransference has left you with as *SC* suggests *"I think that's your job as a therapist isn't it? It's to notice what your feeling and then to think about it rather than act on it cause the danger is you'll act into the countertransference" (91-93; P3).*

Here *PM* recalls the aspects of his mixed countertransference leaving a dissatisfying taste in his mouth. Knowing that he could not rescue or help not only his client, but his clients' partner and the decision to move the process forward was a difficult and hindering aspect to acknowledge. *PM* thus admits that "*knowing that I couldn't do that for them; help, I couldn't help them work that out… there's a bit of helplessness I think with that as well*" (203-204; P 5)

7. Training (contributing factors: super-ordinate theme)

Although theoretical and practical skills were a part of participants' training, all felt that more training in the psychodynamic approach, specifically aspects of transference and countertransference, was needed in order to improve the often complex nature that occurs within the therapeutic relationship.

Preparations (contributing factors: sub-ordinate theme)

On reflection it is clear that training was substantial and good enough to serve its purpose at that particular time to inform *WF's* clinical practice

"I think, well I think its adequate, I don't think its brilliant I think its adequate, erm just for a basic knowledge of I what I need it for here, I would have love to have gone on to do full training cause psychodynamic is my favourite approach… I think the training that I had and the reading that I've done is sufficient for that." (WF, 278-283; P 7)

On the other hand *PM* notices that the little he gained coincided with the little he could produce with his clients. *PM's* knowledge based around transference and countertransference was theoretical, but not relational enough for great practical use. The teachings of others such as his supervisor and doing self- directed study also highlighted his understanding and awareness as depicted below.

"on the course its self, when I did my counselling psychology training, erm we didn't do a huge amount I didn't think on transference or countertransference, we did the psychodynamic module… I guess I was fortunate in that my first year supervisor was purely psychodynamic, so she would often be erm asking me or challenging me in a sense of 'what's happening for me… reading about Patrick Caseman some of his books as well 'internal supervisor' that's helped me I think with developing that sense of countertransference" (PM, 440-453; P 11)

JP reflects that her training highlighted what countertransference was, but rather would have liked more practical scenarios to better handle herself therapeutically in given situations which would make her look at not only the theoretical standpoint but also the practical elements (exercises) as a combination of what belonged to whom within the therapy space.

"*erm, I think its erm you get a background a brief background of what it is, but I think with this with the module a lone I don't think I would have I wouldn't know how to handle it or I wouldn't know how to whether it's something that I would address or I should address or yeah I don't think that was kind of focused on as much, I think it was kind of a blanket approach of 'this is psychodynamic approach' these are the things that you might experience yeah so I don't think the material on the course was erm it gave me those skills, I think what did help was erm taking it to supervision erm and think what made the difference is having a supervisor that knows about countertransference"* (*JP*, 303-310; P 7/8)

Lastly *SC* points out;

"the immediate answer is that I don't think it has [pauses and thinks]…no, I still don't think, no I want to say I don't think it has because I think it, I suppose your training and your reading and all the rest of it makes you aware of it and in particularly when I'm reading I find it really interesting you know 'oh gosh I didn't spot that' or 'oooh I did spot that', so it makes me aware of it but I don't know, I don't know my training particularly helped me to mange it, unless you count the personal therapy element of training as training in which case that probably helped…" (*SC*, 371-379; P9)

Discussion

Summary of Findings

This research had two aims, firstly to explore counselling psychologists' experiences of subjective and objective countertransference and secondly, how this impacts the therapeutic process. As previous research suggests, measurement remains the greatest challenge in capturing experiences of countertransference (Hayes, 2004; Fauth, 2006). Currently the existing research literature focuses heavily on subjective and objective experiences as a single component naming it countertransference, which is contrary to the work of Hayes, McCracken, McClanahan, Hill, Harp and Carozzoni (1998); Rosenburg and Hayes (2002), who identified three countertransference components named *origins, triggers* and *manifestations*. It was not made clear whether those components were subjective or objective categorisations. Therefore to adopt a deeper exploration to this gap and to encourage empirical growth within countertransference, the researcher sought to explore parts of countertransference in a relational manner. This particularly becomes important and insightful tools for a counselling psychologist to utilise within clinical practice because their core foundational base is trained and practiced through the humanistic art of recognising which emotions belong to themselves or their client. The studies' findings therefore further highlight a cohesive, structured understanding of what is actually taking place within the remits of subjectivity/objectivity (through captured experiences) and how we can then build on moving clinical practice forward.

To address this shortfall, the present study attempts to bridge the gap by expanding countertransference to explore subjective, objective and contributory factors as revealed within the findings of this study. Unlike Hayes et al (2002) the findings from this study revealed seven thematic clusters including; *Professional, Personal, Reactors, Clients life outside the Analysis, Service Restrictions, Therapeutic Relationship* and *Training.* As the studies of Nissen-Lie & Stanicke, (2013); and Shorrock, (2011), sought to shed light on conflicted elements that interfere with the therapists' subjective self, this study thus lends its' support by finding out the conflicted elements through its' subjective Super-ordinate and Subordinate themes. This study further adopts the idea that both subjective and

objective parts' of countertransference have additional compartments. Having these then helps the counselling psychologist to immerse in the evoked emotions and what they mean for the individual therapist and the therapeutic process. In support of this research Omylinska-Thurston and James (2011) concur by expressing that before the therapist goes beyond managing the subjective self (within countertransference in particular) for long-term management of the therapeutic relationship; they must process their own inner experiences before moving forward.

However that being said this research also found (within *contributory factors*) that participants often felt that they were limited on choosing to self-disclose or be congruent with sharing their evoked feelings (whether subjective or objective) due to the amount of relational depth they felt they could offer as *Service Restrictions, Therapeutic Relationship* and *Training* swayed the maintenance and outcome of the session. Depending on the particular presenting difficulty, *contributory factors* nonetheless influenced the subjective and objective countertransference. This shows that subjective and objective parts held a great deal of influence upon the therapeutic working alliance.

Additionally with these findings (the subordinate theme of *techniques*, although signposted to the professional super-ordinate theme); should be acknowledged and practically implemented to *subjective, objective and contributory factors* of countertransference when experiencing it. Cartwright and Read (2011) as well as Omylinska-Thurston and James (2011) confirm this by arguing that it is important to have systematic methods and prerequisite to stay present and attuned to the clients' process. It also lends support to Williams et.al (1997) as they found trainee therapists experienced a range of reactions during sessions which inevitably distorted their perception to provide effective therapy and often managed their reactions by 1) using self-awareness 2) focusing on the client and 3) suppressing ones' own feelings and reactions to continue. Consequently, this present study acknowledges what is actually occurring within subjective/objective countertransference and have named parts to facilitate the counselling psychologists' reactions (unlike Williams et.al; 1997 study). Additionally as this study provides *contributory factors* the reactions or responses (often out of the therapists' control) is that much greater. By the

same token, applying not only the techniques learnt from this study, but also that of Williams et.al (1997) can go hand in hand as the management of techniques can offer assistance in processing these internal parts.

Markin, McCarthy and Barber (2012) found that separate parts of countertransference such as feelings and behaviour needs to be examined in their isolated parts. Under those circumstances this study primarily does so to an extent, as it focuses on the feelings more than the behaviours. These feelings were broken down into subjective, objective and contributory factors, yet failed to acknowledge or support the non-verbal behaviours caused by the feelings evoked within the therapist, such as facial expressions, posture or gestures and how that might impact the therapeutic process. Perhaps this is why Markin et al. (2012) wanted close studies of the relationship of transference and countertransference, as it would only be the client within the space observing the reactions of the non-verbal communications presented by their therapist. In fact, Betan, Heim, Conklin and Westen, (2005) employed this idea of assessing clinicians cognitive, affective and behavioural responses, but left out the interactive part of transference as with these findings. And what of longevity? This study captures countertransference and examines the impact of the relationship in the moment of experiencing it, but does not cater for longitudinal exploration on how the relationship changes over time as researched by Dahl, Rosseberg, Bogwald, Gabbard and Hoglend (2012). However, their study fails to give techniques on methods of managing countertransference, nor make it clear whether the four emerging factors '*Confident, Inadequate, Parental and Disengaged'* were subjective or objective countertransference. Subsequently these current findings have adopted future research proposals from Cartwright (2011), who suggested that future studies need to focus on managing countertransference responses both subjectively and objectively.

Rossberg, Karteruda, Pedersenc and Friisa (2010) in general support these present findings by researching objective countertransference, yet on critical reflection whilst objective countertransference measures or provides a window into the clients' world, Markin et al (2012) refutes these findings on the grounds that it is the therapist who is rating the quality of such an interaction. Therefore objective countertransference can be impacted by implicit

or unconscious processes, which may lead to a plethora of objective conclusions, for example defenses, distortions even biases impacting the therapeutic process. However it remains to be said that with these findings, research participants clearly acknowledged that there was a distinctive line or telling point to knowing what belonged to them or their clients, and that being 'aware' or having an 'awareness' was the element of engaging in the process.

Application of the research to Clinical Practice

As countertransference is seen as a complex system involving multiple matrices, as pointed out by Feld (2009), it is safe to say that these research findings reflect such a discourse. It helps the counselling psychologist gain additional benefits and insights into making the process and progress of the therapeutic world one of awareness, understanding and possibility for interpretation and connectedness.

By the same token, the application of this research to clinical practice makes counselling psychologists, (and in extension to other therapists) comprehend that thoughts and feelings are linked to measuring countertransference when transferred unconscious and conscious communication is being presented by the client. It is the therapist's responsibility within practice to sieve through their reactions by noticing what parts of themselves, are being affected and then to compartmentalise the conscious, or to recognise the conscious for what it is and apply ways of moving forward to enhance the therapeutic relationship. This is done by the therapists conveying their emotional entanglement by distinctly separating out what belongs to them, but also what belongs to the client. This then will give insight into the therapist consciously colluding with the clients' conscious awareness. Indeed both the therapist and the client have the ability to change the countertransference narrative at any time and it is with this that awareness of the maintenance of the relationship is to be reflected on. On a separate note, to communicate the inner experiences of the therapist in an authentic manner (Omylinska-Thurston and James (2011) and to manage countertransference, it is important to develop training of techniques to assist counselling psychologists with regards to subjective and objective countertransference. Reflections of

good practice here is then tested by recognition that practitioners have blind spots and that they are willing to question themselves, facilitate their own awareness (through techniques as mentioned) and get back to focusing on their clients needs rather than their own within the moment of experiencing subjective or objective countertransference. This is where helpful or unhelpful countertransference can be made present depending on the situation and clinical judgments/decisions that may perpetuate the therapeutic alliance. In addition it is worth mentioning that the participants who took part in this study were given a detailed information sheet regarding the concept of countertransference. Their familiarity stemmed mainly from the classical Freudian perspective noticeably highlighting the idea of unresolved conflicts from a subjective perspective and understood the idea of evoked feelings felt by themselves and distinguishing if (at all) this belonged to their clients or themselves. More importantly all participants saw themselves as congruent integrative psychologists and actively volunteered by taking part in this study as they felt their skills were good enough to capture the scope of exploring countertransference within research.

In conclusion, the main findings from this research are the following; countertransference is made up of *two* distinctive categories, to understand what *subjective* countertransference is and what *objective* countertransference is, to start adopting a new language when referring to countertransference both in (therapy) and out of the therapeutic space (supervision); for example is it subjective countertransference or objective countertransference being experienced. Subjective countertransference has three components (based on these findings) and it is to recognise how each (personal, professional and reactors) affect, impact the self, the relationship process and the working alliance when experiencing it. Objective countertransference has two layers (primary and secondary levels) where therapist's should recognise the transference and notice that this belongs to the client, yet in the same instance can become moved and affected by the objectivity tapping into once again things belonging to the therapist.

It is therefore recommended that therapist needs to be aware of both the two distinctive categories of their countertransference and how these two interfere with the therapeutic space differently. This awareness will enable therapists or counselling psychologists to

take proper control so that there will be no negative impact.

Overall the researchers contribution to the literature and practice is to provide much needed empirical research within this area, to move the ideas and concepts forward about countertransference by breaking it down into two parts and then further breaking those parts even further. This is to build a better more secure foundational base of understanding and awareness when dealing with/experiencing subjective or objective countertransference in the moment. Disclosing these evoked feelings would give the therapist first and foremost a substantial amount of evidence to fall back on issuing therapeutic change, congruence of communication and managing difficult encounters.

Future Developments

Overall, these aspects (*subjective, objective and contributory factors*) continuously overlap, but future developments should continue to further explore distinctive parts of countertransference. Having the awareness that these elements exist only enhances the nature of a therapists' ability to be more in-tuned, more relational and more accepting of what is going on for both parties. The capacity to improve these findings should focus researchers' attention on exploring both subjective/objective countertransference and the type of diagnosis the client has (e.g. Personality Disorders) and whether this has any impact on the working alliance. Therefore future research would benefit from qualitative investigations of subjective and objective reactions when working with certain populations, for example, diagnosis or symptom-specific and/or certain demographics. As Tishby and Vered (2011), points out that adolescents are a particularly good sample for studying countertransference as by nature their developmental stages provoke strong countertransference feelings inside the therapists. Researchers could for instance explore the impact of countertransference between populations and how this is connected to therapeutic technique, interventions and outcome, using a mixed methods approach. As human judgment can vary widely depending on a plethora of aspects (time of day the interviews are held, the severity of the diagnosis and the current mood of the participants), repetition is needed for overall validity and to move away from only writing and

publishing theoretical papers. As Smith (1999) indicates, because IPA participant numbers are small it is not a representation of the general population, therefore replication of this particular phenomena in this particular way may show significant value.

It is also vitally important to explore the departed space within the therapeutic relationship, such as if the therapist goes on holiday, cancels/re-arranges a session or has a prolonged illness, and how this may impact on the therapeutic process. Further to this, interviewing couples or family systemic groups may assist in moving this area of study forward by focusing more on the subjective impact that this work may have on the therapist.
As mentioned in the limitations, countertransference helps ensue thoughts, feelings and behaviours. Perhaps future research could also look at subjective countertransference thoughts, subjective countertransference feelings and subjective countertransference behaviours as separate dialogues. Like wise objective countertransference thoughts, as well as, objective countertransference feelings and behaviours could be explored separately. Research could further expand this area of investigation with the addition of self-report measures. For example whilst objective countertransference is experienced, it would then be matched with clients' self-report feedback to ascertain whether internal perceptions (feelings/thoughts) of the therapist-client dyad are connected with what the therapist may have experienced. Thoughts, feelings and behaviours should be attempted separately.

All in all, these findings lend empirical support to this area of work, as there are distinctive internal variables taking place that can be categorised, and with these categorisations research should seek to move forward. As Finlay (2006) would point out replicating research will not ensure reliability due to the same researcher asking the same questions, capturing the same stories, but would produce new knowledge, new horizons and new interpretations.

Critical Appraisal

Development as Researcher

In preparation for researching this particular area, my' own experience of countertransference within placement, reading surrounding literature and having peer/supervisory discussions about such a phenomena sparked intriguing dialogue and curiosity. These resources were the foundations to building a better understanding of countertransference before submitting the research proposal. The concept became intriguing and I became drawn to the mysteries of its' interpretative nature.

In particular, pursuing psycho-educational content (for my own understanding) was formulised through reading *Anaylsing Data in Psychology* by Lyons & Coyle (2007) for exploring the type of methodology that I may use when pursuing qualitative work. This book was a great way to explore the different assumptions, practicalities of each method and reporting the analytic outcome step by step. I nonetheless chose IPA over other approaches due to the uniqueness that it employs. As IPA is integrative by nature, for example it encompasses being interpretative, idiographic and psychological, it very much mirrors the application of being an integrative counselling psychologist. The main focus however makes it different from grounded theory, discourse analysis and narrative analysis because it mainly focuses on the lived experience of the individual. Baring this in mind, IPA has a plethora of historical influences, it allows the researcher to encompass detailed analysis with small numbers, it is subjective and the freedom to explore transcripts using notes and commentary whilst being also an inductive approach. This by its very amalgamation of interests relates to the profession of counselling psychology; the intricate, detailed, descriptive and subjective being, sharing lived experiences within the therapeutic space.

Though the methodological approach and the professional identity of a counselling psychology seem to go hand in hand, there were often difficulties distinguishing my own identity as not only a researcher but also as a psychotherapeutic practitioner. The

boundaries and telling points of separating out, being able to therapeutically hold and contain someone without providing therapy during the pilot interview schedule was useful and insightful for the subsequent interviews. This gave me an opportunity to gain a sense of balance between being therapeutically relational yet at the same time, to appreciate how and when to focus on the task in hand and gain the necessary information competently, informatively and ethically.

In addition, within the real research interview schedule, I experienced double hermeneutics as well as parallel processing due to connecting with the vast narratives expressed. There were times where my interpretations of the participant's interpretation made meaning-making a vast phenomenon. Not only were there processes happening within the room between the research participant and I (often an element of created transference and countertransference). But also there was a relationship formed by the research participant and the research participants' client (as an extension of their already established therapeutic alliance). As well as there being a formed relationship both on a systemic, relational and reflective level both with and the client (s) and I. (Hawkins & Shoet, 2012). It is worth noting that the narratives being shared with me often moved and shifted something within the research participants through their own self-examination and I can only wonder if such significant contribution impacted the research data. At times this was evident by their non-verbal cues such as their body language, facial expressions, and the under layers being spoken. However, I was careful not to adjust myself by becoming a therapist in the moment; by wanting to summarise, reflect back, unravel the story, break it down, highlight keywords and at times rescue their vulnerabilities. Rather I had to stick to probing and prompting questions related to the topic at hand with the experience of the participant and their narrative being told. This was indeed a hard juggling act to practice as my own evoked feelings were attuned to counsel, yet my awareness of being emotionally distant in that regard, withdrew feelings of attachment to rescue, but rather to research. Whilst I felt that I had a great rapport with every research participant, perhaps due to our shared counselling psychology background, there was an emotional affinity underpinning this fellow insight orientated role (Rizq & Target, 2009). The nature therefore of having to ignore or refrain from operating from a person-centred therapeutic base, quickly left me

operating from a person-centred researchers' base by conceptualising and developing my own sense of what a researcher's identity felt and looked like.

Development as Practitioner

As a Practitioner, the realisation and identification that countertransference is not an escapable procedure but rahter will undoubtedly influence a plethora of measures within the therapeutic process, is a helpful awareness to have. Not only does it affect the therapist (cognitively, emotionally and behaviorally), the immediate relationship, and the maintenance of the working alliance, but it influences the atmosphere and systems around it deliberately or otherwise. Nevertheless, flexible strategies of countertransference through these presented findings, is a way of accommodating new thinking within clinical practice (Jones, 2004). Countertransference will continue to be a complex reactive response that will have layers of purpose, undertones, and even unconscious goodness amongst many other things. Consequently, being able to categorically highlight significant human encounters into separated areas helps counselling psychologists' practice clinical work more effectively and understand self awareness that much more. As Markin *et al* (2012) proposes, transference and countertransference will always interact and with this interaction predicts the outcome of therapy. Therefore practitioners need to understand their own internal positioning (the intensity countertransference offers), which will have external repercussions (positive/negative outcomes or frequency of session). As a developing practitioner being aware of the continued perpetual cycle that is counter-evoked gives scope to the exploratory and meaningful content. Hence, these findings are guidelines in adequate internal understanding and a manual to having a good enough baseline to pursue good work. Equally, the role of supervision must be considered, as countertransference will influence the client, the therapist and the supervisor. This data therefore indicates that at any point therapists' can tap into their own 'internal supervisor' in the moment of experiencing difficult subjective and objective countertransference (within the therapeutic space) by utilising the techniques found in the subjective professional super-ordinate theme. However countertransference will benefit this triad (the client, the therapist and the supervisor) outside of the therapeutic space by congruently bringing a more detailed awareness of the self through introspective, retrospective and

systemic means.

As IPA is interested in idiographic approaches, which focus on the particular, meaning exploring detailed accounts before making a more generalised assumption. IPA continuously concerns itself with peoples' personal meaning and their sense making given a particular experience. As a counselling psychologist in training these qualities go hand in hand with IPA's theoretical foundations. They both recognise the individual's epistemological position, formulate subjective information for further exploration and take time to highlight intricate narrative parts of someone and aid the overall situation being experienced. This gives practitioners a better understanding of the human experience and being humanistic/person-centred (Rogers,1957; Mearns & Thorne, 2005) is a constant reminder that in anything we attempt to do, this base provides all interactions, philosophical understanding, collective awareness and also the very uniqueness that each person holds.

As a practitioner it is clear that I am actively involved in co-constructing the phenomena (in this case countertransference) by mere presence and influence (Willig, 2008). Having the awareness of what is taking place can better inform me of my unique intervention styles and the manner in which to approach my clients. Inducing insight into how my own personal values, perspective, and morals can mirror the presence of someone else sharing the therapeutic space is a rewarding experience.

Upon reflection, starting out as a new practitioner experiencing countertransference, is one of the biggest challenges faced where the 'stuck feelings' of the often complex difficulties that came into the therapy room, were experienced. With regards to the present study it clarifies and validates clinical practice by indicating where the 'stuck feelings' may arise and helps unpick the process to inform the working alliance, the outcomes and co-created management of it.

Limitations

Overall, this study provides evidence for exploring subjectivity and objectivity in depth by helping label parts of these isolated areas for a greater understanding for the counselling psychologist. With this in mind there are some limitations worth exploring. The *feelings*

aspect of this study is very much examined in their isolated parts, but still behaviours remain to be researched. Though this study does not show how longitudinal exploration on how the relationship changes over time as indicated by Dahl, Rosseberg, Bogwald, Gabbard and Hoglend (2012), that being the case, it also limits itself by not facilitating how the relationship changes within the session (when all types of countertransference is experienced) and how the therapist is rating the quality of the interaction whilst it impacts the therapeutic process. As a final point depending on particular diagnosis, this may vary in emotional responses from the client and as this study shows with different diagnosis there is a collective commonality, it still limits in the area of paying attention to one.

Personal Reflexivity

There has been such growth for me in exploring countertransference, as in the beginning of this course not much ground was covered concerning countertransference and it was only in year three that theory to practice was extensively taught. Whereas for the duration of the first two years being on placement, practice based evidences of countertransference was only identified through the occurrence of experiences. The passion to understand what happens intricately to parts of the self and how to recognise them for better practice has always been the ultimate goal in pursuing this particular research. For me, these findings have impacted my own work with my clients as I have a fundamental base that I can go to in order to thoroughly understand what belongs to me, or my client both subjectively and objectively when countertransference is taking place. I now have options when evoked emotions are present, whereas I did not feel I did before. Therefore, through the process of elimination I can narrow down what belongs to who in the therapeutic space and where I think these feelings may originate from to interpret the dynamics being played out between the client and I. Furthermore, I have a better awareness of what to do with the feelings experienced through many techniques these findings have pin pointed and having this wider knowledge I am able to practice them safely and ethically.

However, taking a step back, the journey in getting to this point was indeed a frustrating, time consuming and difficult process to manage. From the long delays of ethical approval, to gaining access to participants via advertising through a plethora of platforms, often felt

like an idea that would never come to fruition. In the back of my mind the momentum that kept me on track was knowing that I may be adding value to research, that I would eventually be capturing authentic, descriptive and unique experiences from research participants, which this may also benefit others in the long run within their own body of clinical work.

Certainly, there were a large number of issues that I was not prepared for throughout this journey, which I often questioned my capabilities at times. For example employing the pilot study and receiving feedback regarding the overall data-gathering techniques evoked emotional responses as admitting that the structure/content needed re-vising and the amount of time they each needed was a hard pill to swallow. Nonetheless I wanted to be an effective researcher, which by doing this pilot study taught me great ways to consider areas of strengths and weaknesses for further development.

Eventually, selecting actual research participants to interview involved a busy workload from setting up the time, date, confidential space with good conditions to conduct and record the interview. Not to mention, both the participant and I being mentally/emotionally prepared to withstand the narratives being explored alongside the probing and prompting of added questions. I was very rigorous with timescale, meaning not having one interview after another but, gave myself time to process and reflect in between gathering each individual responses. This often gave me breathing space to consider writing in my journal and make notes surrounding the overall dynamics. Upon reflection I am happy that I took the initiative to do so. In fact this helped me when it came to analysing each set of data as I already felt that I was enthralled and submerged within the framework.

Data Analysis was not an easy task to attempt. It involved many hours of transcribing and analysing in depth with accordance to specified techniques that I was employing from a plethora of authors. This was done alongside large amounts of hand written, highlighted coverage of initial comments, emergent themes and so forth. This by far was that most complex with the added pressure of juggling writing my literature review. Often I felt blocked and anxious when writing as unfortunately life still continues such as work, university, clinical placement and family. Therefore coping with it all often felt

overwhelming. However, the main thing that helped me the most was getting into a rhythm of writing, often having designated days purely for parts of my thesis to be looked at and also having boundaries with how long I needed to spend on a section for that day.

Overall, researching such an area has been a tough and exhausting procedure because it is hard to capture evoked feelings, as they are flexible, adaptable and forever changing depending on the circumstance. Yet, I think that in a therapeutic alliance it is much easier to separate, conceptualise, utilise and make use of these separated areas that are ultimately beneficial to help not only clients but also therapists. As a counselling psychologist I stride for a collaborative working relationship with an ebb and flow or give and take element, so by nature although I may at times have a need to rescue my clients, these findings have helped me become much more prepared and equipped when faced with my own blind spots. It is apparent that therapists are an important part of this process and who unfortunately do not come into the space with blank slates, but rather connections of similarities and differences in the context of experiencing subjective and objective countertransference. To conclude, as Mearns & Thorne (2007) state, new awareness cannot be forgotten or unchanged and therefore there is a choice in the matter of exercising locus of control.

References

Ashworth, P. (2003). An approach to Phenomenology: the contingencies of the life world. *Journal of Phenomenology Psychology, 34*(2), 145-156.

Barrett, JL. (2001). How ordinary cognition informs petitionary pray. *Journal of Cognition and Culture, 1*(3), 259-69

Bearse, J., McMinn, M., Seegobin, W., & Free, K. (2013). Barriers to psychologists seeking mental health care. *Journal of Professional Psychology: Research and Practice, 44*(3), 150-157.

Bennett-Levy, J., & Thwaites, R. (2007). Self and self-reflection in the therapeutic relationship: A conceptual map and practical strategies for training, supervision, and self-supervision of interpersonal skills. In P. Gilbert & R. Leahy (Eds.), *The therapeutic relationship in the cognitive behavioral psychotherapies* (pp. 255–282). London: Routledge.

Betan, E., Heim, A. K., Conklin, C. Z., & Westen, D. (2005). Countertransference phenomena and personality pathology in clinical practice: An empirical investigation. *American Journal of Psychiatry, 16(2)*, 890-898.

Biancoli, R. (2002). Psychoanalyst's Values and Countertransference. *International Forum Psychoanalytical,* 11, 10-17

BPS, (2004). Widening access within undergraduate psychology education and its implications for professional psychology: Gender; disability and ethnic diversity. Leicester: Author.

BPS, (2009). Code of Ethics and Conduct Guidance. Leicester: British Psychological Society

BPS, DCoP. (2005). Professional Practice Guidelines. Leicester: British Psychological Society.

Bradley, J. (2013, December). Where are all the men? [Letter to the editor] Therapy Today. Retrieved 21 March 2014 from www.therapytoday.net/article/show/4052/British Psychological Society (2004). Widening access within undergraduate psychology education and its implications for professional psychology: Gender; disability and ethnic diversity. Leicester: Author.

Brody, F., & Farber, B. (1996). The effects of therapist experience and patient diagnosis on countertransference. *Psychotherapy, 33*, 372-380.

Cartwright, C. (2011). Transference, countertransference, and reflective practice in cognitive therapy. *Clinical Psychologist,* 15, 112-120

Cartwright, C., & Read, J. (2011). An Exploratory Investigation of Psychologists' Responses to a Method for Considering "Objective" Countertransference. *New Zealand Journal of Psychology. 40*(1)

Clegg, J., & Moissinac, L. (2005). A relational theory of self-deception. *New Ideas in Psychology,* 23, 96-110.

Cohen, L., Manion, L., & Morrison, K. (2007). Research methods in education (6th ed.). London, UK: Routledge.

Colson, D., Allen, J., Coyne, L., Dexter, N., Jehl, N., Mayer, C., et al. (1986). An anatomy of countertransference: Staff reactions to difficult psychiatric patients. *Hospital Community Psychiatry, 37*, 923-928.

Cooper, M. (2008). Essential Research Findings in Counselling and Psychotherapy. Sage Publications Ltd. *Journal of Clinical Psychology*, 56, 1221-1235.

Crossley, M. (2007). Narrative analysis. In Lyons, E., & Coyle, A. **(**Eds) (2007). *Analysing Qualitative Data in Psychology* (pp.131-144). London: Sage.

Cutler, R.L. (1958). Countertransference effects in psychother- apy. *Journal of Consulting Psychology, 22* (5), 349-356.

Dahl, H., Rossberg, J., Bogwald, K., Gabbard, G., & Hoglend, P. (2012). Countertransference feelings in one year of individual therapy: An evaluation of the factor structure in the Feeling Word Checklist-58. *Psychotherapy Research*, *22*(*1*), 12-25

Department of Health (2002). Women's mental health: Into the mainstream. London: Author.

Downey, G., Freitas, A., Michaelis, B., & Khouri, H. (1998). The self-fulfilling prophecy in close relationships: Rejection sensitivity and rejection by romantic partners. *Journal of Personal and Social Psychology*, *75*, 545-560.

Eatough, V., & Smith, JA. (2008). Interpretative phenomenological analysis. In: Willing C, Stainton-Rogers W (eds) The Sage handbook of qualitative research in psychology, pp 179-194. Los Angeles, Sage.

Elliott, R., & Zucconi, A. (2006). Doing research on the effectiveness of psychotherapy and psychotherapy training: a person-centered/experiential perspective. Person- *Centered & Experiential Psychotherapies,* 5, 81-100

Elliot, S., Lowenthal, D., & Greenwood, D. (2007). Narrative Research Into Erotic Countertransference -Transference in a Female Therapist–Male Patient Encounter. *Psychoanalytic Psychotherapy, 21*(3), 233-249

Fauth, J., and Hayes, J.A. (2006). Counselors' Stress Appraisals as Predictors of Countertransference Behavior With Male Clients. *Journal of Counseling & Development* 84, 430-439

Fauth, J. (2006). Towards more and better countertransference research. *Psychotherapy: Theory, Research, Practice, Training, 43*(1), 16-31.

Feld, B. (2009). Holding and Facilitating Interactive Regulations on Couples with Trauma Histories. *Psychoanalytic Inquiry, 24*(3), 420 -437

Finlay, L. (2006). 'Rigour','ethical integrity' or 'artistry'? Reflexively reviewing criteria for evaluating qualitative research, *British Journal of Occupational Therapy 69*(7), 319-326.

Fosshage, J. (1995). Countertransference as the analyst's experience of the analysand: Influence of listening perspectives. *Psychoanalytic Psychology*, *12*(3), 375-391

Freud, S. (1953). Fragment of an analysis of a case of hysteria. In J. Strachey (Ed.), The standard edition of the complete psychological works of Sigmund Freud (vol. 7, pp. 15–122). London: Hogarth Press. (Original work published in 1905)

Fromm-Reichman, F. (1950). Principles of intensive psycho- therapy. Chicago: University of Chicago.

Gabbard, G. (1995). Countertransference: The emerging common ground. *The International Journal of Psychoanalysis,* 76, 475-485.

Gabbard, G. (2001). A contemporary psychoanalytic model of countertransference. *Journal of Clinical Psychology*, *57*, 983-991.

Gabbard, G. (2004). *Long-term psychodynamic psychotherapy: A basic text*. Arlington, VA: American Psychiatric Association

Gabbard, G. (1999). Countertransference issues in Psychiatric Treatment (Review of Psychiatric Series; Oldham JM and Riba MB, series eds.) American Psychiatric Press.

Gelso, C J. (2000). The Development of the Inventory of Countertransference Behavior. *Journal of clinical Psychology, 56*(9), 1221-1235

Gelso, Latts, Gomez and Fassinger. (2002). Countertransference Management and Therapy Outcome: An initial Evaluation. *Journal of Clinical Psychology* 58: 861-867

Geltner, P. (2006). The Concept Of Objective Countertransference and its Role in a Two-Person Psychology. *The American Journal of Psychoanalysis, 66*(1), 25-42

Haarhoff, B. (2006). The importance of identifying and understanding therapist schema in cognitive therapy training and supervision. *New Zealand Journal of Psychology*, *35*, 126-131.

Habermas, J. (1984). The Theory of Communicative Action. Reason and the rationalization of society. MA: Beacon

Hafkenschied, A. (2012). Assessing Objective Countertransference with a Computer-Delivered Impact Message Inventory (IMI-C). *Clinical Psychology and Psychotherapy.* 19, 37-45

Harre, R. (1979). Social Being. Oxford: Blackwell.

Hawkins, P., & Shohet, R. (2012). Supervision in the Helping Professions (Supervision in Context). Open University Press McGraw-Hill.

Hayes, J.A. (2004). The inner world of the Psychotherapist: A program of the Research on Countertransference. *Psychotherapy Research 14*(1), 21-36

Hayes, J.A., Riker, J.R., & Ingram, K.M. (1997). Countertransference behavior and management in brief counseling: A field study. *Psychotherapy Research,* 7, 145-153.

Hayes, J.A., McCracken, J.E., McClanahan, M.K., Hill, C.E., Harp, J.S., & Carozzoni, P. (1998) Therapist perspectives on countertransference: Qualitative data in search of a theory: *Journal of Counselling Psychology,* 45, 468-482.

Hayes, J., and Gelso, C. (2001). Clinical implications of Research on Countertransference: Science informing Practice. *Journal of Clinical Psychology*, *57*(8), 1041-1051

Hayes, J., Gelso, C., & Hummel, A. (2011). Managing countertransference. *Journal of Psychotherapy, 48*(1), 88-97

HCPC. (2010*).* Standards of Proficiency: Practitioner Psychologists. London: Health & Care Professions Council.

HCPC. (2008). Guidance on Conduct and Ethics for Students. London: Health & Care Professions Council.

HCPC. (2009). Standards of conduct, performance and ethics. London: Health & Care Professions Council.

Heidegger, M. in Wilberg, H.P. (1998) Being and Listening. Third Ear Publications

Heimann, P. (1950). Countertransference. *British Journal of Medical Psychology, 33,* 9-15.

Heimann, P. (1950). On Counter-Transference. International Journal of Psycho-Analytic 31, 81-84

Hinshelwood, R. (2012). On being objective about the subjective: Clinical aspects of intersubjectivity in contemporary psychoanalysis. *International Forum of Psychoanalysis*. 21, 136-145

Hollway, W., and Jefferson, T. (2013, 2nd ed.). Doing Qualitative Research Differently: Free Association, Narrative and the Interview Method. London: Sage

Hoy, D. The Critical Circle: Literature, History, and Philosophical Hermeneutics (1978); K. Mueller-Vollmer, ed., The Hermeneutics Reader (1985).

Ivey, G. (2013). Cognitive Therapy's Assimilation Of Countertransference: A Psychodynamic Perspective. *British Journal of Psychotherapy 29*(2), 230-244

Jones, A. (2004). Transference and Countertransference: *Perspectives in Psychiatric Care 40*(1), 13-19

Kahneman, D. (2011). Thinking Fast and Slow. Reprint edition. New York: Farrar, Straus and Giroux.

Karamanolaki, H. (2012). The difficulty of being together without being the same: Identifications and differentiations in countertransference. *International Forum of Psychoanalysis*. 21, 189-194

Kernberg, O. (1965). Notes on countertransference. *Journal of the American*

Psychoanalytic Association, 13, 38–56.

Kiesler, D. (2001). Therapist countertransference: In search of common themes and empirical referents. *Psychotherapy in Practice, 57*, 1053- 1063.

Kohut, H. (1984). *How does analysis cure?* Chicago: University of Chicago Press.

Langdridge, D. (2007). Phenomenological Psychology: Theory, Research and method. Person Prentice Hall: England

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 3,*102-120

Latts, M.G., Gelso, C.J., Gomez, M.J., & Fassinger, R.E. (1998). The management of countertransference as related to therapy outcome. Unpublished manuscript, University of Maryland, College Park, MD

Laufer, B. (2010). Beyond countertransference: Therapists experiences in clinical relaitonships with patients diagnosed with schizophrenia. *Social and Integrative Approaches, 2*(2), 163-172

Leahy, R. (2007). Schematic mismatch in the therapeutic relationship: A social cognitive model. In P. Gilbert

Leahy, R. (2008). The therapeutic relationship in the cognitive behavioral psychotherapies London: Routledge.

Little, M. (1951). Countertransference and the patient's response to it. *International Journal of Psychoanalysis, 32,* 32–40.

Luborsky, L.A., & Crits-Christoph, P. (1998). Understanding transference: The CCRT method. Washington DC: American Psychological Association.

Lyons, E., & Coyle, A. (2007). Analysing Qualitative Data in Psychology. SAGE Publications

Markin, R., McCarthy, K., & Barber, J. (2012). Transference, countertransference, emotional expression, and session quality over the course of supportive expressive therapy: The raters' perspective. *Psychotherapy Research, 117*

Markin, D. (2009). Exploring a method for transference assessment in group therapy using the social relations model: suggestions for future research. *The journal for specialists in group work, 34*(4), 307-325

McClure, B.A., & Hodge, R.W. (1987). Measuring countertransference and attitude in therapetutic relationships. *Psychotherapy*, 24, 325-335

Mearns, D., & Cooper, M. (2005). Working at relational depth in counselling and psychotherapy. London: Sage Publications.

Mearns, D., and Thorne, B. (2007). *Person-Centred Counselling in Action.* 3rd ed. London: SAGE Publications Limited.

Mearns, D., and Thorne, B. (2000). Person-Centred Therapy Today – New Frontiers in Theory and Practice. London: Sage Publications Limited.

Melnick, J. (2003). Countertransference and the gestalt approach. *British Gestalt Journal, 12,* 40-48

Merleau-Ponty, M. (1962). Phenomenology of Perception. London: Routledge & Kegan Paul.

Mølbak, R. (2012). From a Phenomenology of the Subject to a Phenomenology of the Event: Reconstructing the Ontological Basis for a Phenomenological Psychology. *Journal of Phenomenological Psychology,* 43, 185-215

Morison, L., Trigeorgis, C., and John, M. (2014). Are mental health services inherently feminised? *The psychologist,* 27, 414-417

Naden, D. (2009). Hermeneutics and observations- a discussion. *Nursing* (1), 75-81

Nissen-Lie, H., and Sta¨nicke, E. (2014).“Yes, Of Course It Hurts When Buds Are Breaking”: Therapist Reactions to an Adolescent Client’s Sexual Material in Psychodynamic Psychotherapy. *Journal of Clinical Psychology: In Session, 70*(2), 160-169

Omylinska-Thurston, J., and James, P. (2011). The therapists use of self: A closer look at the process within congruence. *Counselling Psychology Review, 26*(3), *20-33*

Osborne, J. W. (1990). Some basic existential-phenomenological research methodology for counsellors. *Canadian Journal of Counselling*, 24, 79-91

Panken, S. (1981). Countertransference reevaluated. *The Psychoanalytic Review*, 68, 24-44.

Pontuso. (2014). Being, Time, and Art: Solzhenitsyn's Reflections on Heidegger's Question. *Society 51*(2), 156-168

Racker, H. (1957). The meanings and uses of countertransference. *Psychoanalytic Quarterly, 26*, 303-357.

Rathe, E. (2008). Transference and Countertransference form modern psycholanalytic perspective. North American Association of Christians in Social Work.

Reich, A. (1951). On countertransference. *International Journal of Psycho-analysis*, 32, 25-31.

Reicher, S. (2000). Against methodolatry: some comments on Elliott, Fischer and Rennie. *British Journal of Clinical Psychology*, 39, 1- 6.

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience, *The Psychologist*, 18, 20-23.

Ricoeur, P. (1970). Freud and philosophy: An essay on interpretation. New Haven, CT: Yale University Press.

Riley, J. (1990). Getting the most from your data: A Handbook of practical ideas on how to analyse qualitative data.

Rizq, R. (2005). Ripley's Game: Projective identification, emotional engagement, and the counselling psychologist. *Psychology and Psychotherapy: Theory, Research and Practice* 78, 449-464

Rizq, R., & Target, M. (2009). 'The power of being seen': An interpretative phenomenological analysis of how experienced counselling psychologists describe the meaning and significance of personal therapy in clinical practice. *Counselling Psychology Review, 24, Nos. 3 & 4,*

Roberts, T. (2013). Understanding the research methodology of interpretative phenomenological analysis. *British Journal of Midwifery, 21*(3).

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 22, 95-103

Rosenberger, E., and Hayes, J. (2002). Therapist as subjective: A review of the Empirical Countertransference Literature. American Counselling Association

Rosenbloom, S. (1998). The complexities and pitfalls of working with the countertransference. *Psychoanalytic Quarterly,* 67: 256-75.

Røssberg, J.I., Hoffart, A., & Friis, S. (2003). Psychiatric staff members' emotional reactions toward patients. A psychometric evaluation of an extended version of the Feeling Word Check- list (FWC-58). *Nordic Journal of Psychiatry*, 1, 45-53

Røssberg, J.I., Karterud, S., Pedersen, G., & Friis, S. (2010). Psychiatric symptoms and countertransference feelings: An empirical investigation. *Psychiatry Research*, 1,191-195.

Seager., M and Wilkins, D (2014). Being a Man - putting life before death. *The Psychologist,* 27, 404-405.

Shafranske, E., & Falender, C. (2008). Supervision addressing personal factors and countertransference In C. Falender & Shafranske, E. (Eds.), *Casebook for clinical supervision: A competency-based approach* (pp. 97–120). New York: American Psychological Association.

Shay, J.J. (1993). Should Men Treat Couples? Transference, Countertransference, and Sociopolitical Considerations. *Psychotherapy, 30,* 93-102

Shinebourne, P. (2011). Interpretative Phenomenological Analysis. In N. Frost (ed). *Qualitative Research Methods in Psychology: Combining core approaches*. Open University. p.44- 65.

Shorrock, M. (2011). The philosophical challenges within counseling Psychology: Can Egan's Model Help? *Counselling Psyhcology Review, 26(*3)

Singer, B. A., & Luborsky, L. (1977). Countertransference: The status of clinical versus quantitative research. In A. S. Gurman & A. M. Razdin (Eds.), *Effective counseling: Handbook of research* (pp. 433-451). New York: Pergamon Press.

Smith, J., and Osborn, M. (2004). Interpretative phenomenological analysis. In G. Breakwell (ed) *Doing Social Psychology*. Oxford: Blackwell. (pp 229-254)

Smith, J.A. (1996). Beyond the divide between cognition and discourse: Using Interpretative Phenomenological Analysis in health psychology. *Psychology and Health*, 11, 261-271

Smith, JA., Harré, R., & Van Langenhove, L. (1995). Idiography and the case study. In: Smith JA, Harré ,R., & Van Langenhove L (eds) Rethinking psychology, 57-69. London, Sage.

Smith, J., Flower, P., and Larkin, M. (2009). Interpretative Phenomenological Analysis: Theory, Method and Research. London sage

Smith, J.A. (2007). Qualitative Psychology: A Practical Guide to Research Methods. London Sage.

Stolorow, R., & Lachmann, F. (1984/1985). Transference: The future of an illusion. Annual of Psychoanalysis, 12-13, 19–37.

Stolorow, R. D. (1991). The intersubjective context of intrapsychic experience: A decade of psychoanalytic inquiry. *Psychoanalytic Inquiry*, 11, 171–184.

Swann, W. (1997). The trouble with change: Self-verification and allegiance to the self. *Psychological Science, 8*, 177-180.

Tada, (2013). Edmund Husserl in Talcott Parsons: Analytical Realism and Phenomenology. *Humanities Studies* 36, 357-374

Tishby, O., & Vered, M. (2011). Countertransference in the treatment of adolescents and its manifestation in the therapist-patient relationship. *Psychotherapy Research, 21*(6), 621-630

Wagstaff et al. (2014). The Accordion and the Deep Bowl of Spaghetti: Eight Researchers' Experiences of Using IPA as a Methodology. *The Qualitative Report* 19, Article 47, 1-15

Walker, M. (2004). Supervising practitioners working with survivors of childhood abuse: counter transference; secondary traumatization and terror. *Psychodynamic Practice*, *10*(2), 173-193

Wampold, B. (2010). The research evidence in common factor models: A historically situated perspective. In B. Duncan, S. Miller, B. Wampold, & M. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (pp. 49–83). Washington, DC: American Psychological Association.

Waska, R. (2013). Working to understand our role in the patient's mind: Countertransference and the problem of immersion**.** *British Journal of Psychotherapy 29*(4), 466-480

Watkins, C.E. (1985). Countertransference: Its impact on the counseling situation. *Journal of Counseling and Development*, 63, 356-359.

Wilkins, P. (1997). Congruence and Countertransference: Similarities and Differences. Counselling, Journal of the British Assosciation for Counselling, 8*(1)* 36-41

Williams, E., Judge, A., Hill., Clara., and Hoffman, Mary. (1997). Experiences of novice therapists in prepracticum: Trainees', clients', and supervisors' perceptions of therapists' personal reactions and management strategies. *Journal of Counseling Psychology, 44*(4), 390-399

Willig, C. (2008). Introducing Qualitative Research in Psychology. Open university Press

Willig, C. (2001). Introducing qualitative research in psychology: adventures in theory and method. Buckingham: Open University Press.

Winnicott, D.W. (1949). Hate in the countertransference. *International Journal of Psychoanalysis,* 30, 69-75.

Woolfe, R., Strawbridge, S., Douglas, B and Dryden, W. (2010) 'Handbook of Counselling Psychology. (3rd Edition). SAGE Publications ltd

Yalom, I. D., & Leszcz, M. (2005). The theory and practice of group therapy. New York: Basic Books.

Zachrisson, A. (2009). Countertransference and changes in the conception of the psychoanalytic relationship. *International Forum of Psychoanalysis* 18: 177-188

APPENDICES

Contents

Appendix 1:

Submission For ethical Form Approval

ETHICAL APPROVAL FORM

UNIVERSITY OF WOLVERHAMPTON
KNOWLEDGE ▪ INNOVATION ▪ ENTERPRISE

4. Ethical Approval Form

Please complete and submit the three components, which together make up the ethical approval form document – (i) The Researcher Checklists; (ii) Investigator, Supervisor & Research project details; and (iii) your Protocol.

4.1 Researcher Check Lists (Part A) [1]

Once you have answered all the questions below and the relevant documents have been included please send this to your supervisor for submission.

Procedural Aspects Prompts *This is the first researcher checklist and aims to help ensure you have addressed all the salient procedural aspects of the ethical approval process. It should be submitted completed as part of your ethics application form. If you answer No to any of the items below, your submission is likely to be returned to you without being reviewed.*			
1. Have you completed and included all three parts of the submission document? *i. Researcher Checklists* *ii. Researcher, Supervisor & Research Project details* *iii. Your Research Protocol with Appendices*	*Yes* ☒	*No* ☐	*N/A* ☐
2. Does your project protocol include an electronic signature from your supervisor? (For supervised projects only)	*Yes* ☐	*No* ☐	*N/A* ☒
3. Is your proposal 1,500 words (+ or – 10%)?	*Yes* ☒	*No* ☐	*N/A* ☐
4. Have you included ALL necessary Appendices documents?	*Yes* ☒	*No* ☐	*N/A* ☐

[1] To complete the checklist boxes either double click and select checked or right click select properties and then select checked. If you select the wrong box and cancel, rather than selecting checked or unchecked, the box will disappear, undo to make the box reappear.

i. Original letter of access and/or approval letter from organisation	*Yes* ☐	*No* ☐	*N/A* ☒
ii. Letter/Email Inviting participants to take part	*Yes* ☒	*No* ☐	*N/A* ☐
iii. Consent form	*Yes* ☒	*No* ☐	*N/A* ☐
Iv Consent form involving access to medical records	*Yes* ☐	*No* ☐	*N/A* ☒
v. Participant information sheet	*Yes* ☒	*No* ☐	*N/A* ☐
vi. Debrief sheet	*Yes* ☒	*No* ☐	*N/A* ☐
vii. Data Collection Materials & Procedures (e.g. questionnaires, interview schedules, training/intervention details etc.)	*Yes* ☒	*No* ☐	*N/A* ☐

UNIVERSITY OF WOLVERHAMPTON
KNOWLEDGE ▪ INNOVATION ▪ ENTERPRISE

Ethical Approval Form

Ethical Consideration Prompts *This is the second researcher checklist and aims to help ensure you have addressed all the salient ethical issues. It also aims to help you to decide if your study is a category A or category B project. It should be submitted completed as part of your ethics application form*			
1. Will you describe the main research procedures to participants in advance, so that they are informed about what to expect?	*Yes* ☒	*No* ☐	*N/A* ☐
2. Will you tell participants that their participation is voluntary?	*Yes* ☒	*No* ☐	*N/A* ☐
3. Will you obtain written consent for participation?	*Yes* ☒	*No* ☐	*N/A* ☐
4. Will you avoid coercion?	*YES*		
5. If the study involves observational data collection, will you ask participants for their consent to being observed?	*Yes* ☐	*No* ☐	*N/A* ☒
6. Will you tell participants that they may withdraw from the research at any time without giving a reason and with no repercussions?	*Yes* ☒	*No* ☐	*N/A* ☐
7. With questionnaires, will you give participants the option of omitting questions they do not want to answer?	*Yes* ☐	*No* ☐	*N/A* ☒
8. Will you tell participants who will have access to their data?	*Yes* ☒	*No* ☐	*N/A* ☐
9. Will you tell participants that their data will be treated with full confidentiality (detailing data protection and storage procedures) and that, if published, data will be anonymised?	*Yes* ☒	*No* ☐	*N/A* ☐
10. Will you debrief participants at the end of their participation (i.e. give them a brief explanation of the study).	*Yes* ☒	*No* ☐	*N/A* ☐
11. Will you provide participants with the option of receiving a lay summary of the main findings?	*Yes* ☒	*No* ☐	*N/A* ☐
12. Will your study involve deliberately misleading participants in any way? (Category B)	*Yes* ☐	*No* ☒	*N/A* ☐
13. Is there any realistic risk of any participants experiencing either physical or psychological distress or discomfort? If Yes, give details in the ethical issues section of in Part B and/or in your Protocol (Part C) and state how this will be handled (e.g. who the participant can contact for help). (Category B)	*Yes* ☐	*No* ☒	*N/A* ☐
14. Does your study involve work with animals? (Category B)	*Yes* ☐	*No* ☒	*N/A* ☐
15. Do participants fall into any of the following special groups? (Category B) — Schoolchildren (under 18 years of age)	*Yes* ☐	*No* ☒	*N/A* ☐
People with learning or communication difficulties	*Yes* ☐	*No* ☒	*N/A* ☐
Patients/Clients (including people	*Yes* ☐	*No* ☒	*N/A* ☐

Note that you may also need to obtain satisfactory CRB clearance (or equivalent for overseas students).	with diagnosed psychological of health conditions)			
	People in custody or offenders	*Yes* ☐	*No* ☒	*N/A* ☐
	Other vulnerable groups (e.g. victims, homeless people, substance misusers, etc.)	*Yes* ☐	*No* ☒	*N/A* ☐
16. Does your study involve collecting sensitive secondary data (e.g. records regarding cause of death, abuse, neglect etc.) (Category B)		*Yes* ☐	*No* ☒	*N/A* ☐
17. Is this study going to an external ethical review committee (e.g. IRAS, REC, NOMS etc.), if so please give details below.		*Yes* ☐	*No* ☒	*N/A* ☐
External Approval will be sought from:				

You must bring to the attention of the Ethics Committee any additional issues with ethical implications not covered by the above checklist.

UNIVERSITY OF WOLVERHAMPTON
KNOWLEDGE ▪ INNOVATION ▪ ENTERPRISE

Ethical Approval Form

4.2 Investigator, Supervisor & Research Project details (Part B)

Investigator's Details (Must be completed)

Title: Miss
Forename: Drusilla
Surname: Joseph
Position: Trainee Counselling Psychologist
Qualifications/Expertise of the investigator relevant to the submission: BSc, Grad Dip
Email address: drusillaj1@gmail.com / D.Joseph@wlv.ac.uk
Address: Flat 2, 182 Leander Road, Brixton Hill London
Postcode: SW2 2LL
Telephone number: 07506992068
Alternative contact number:

Supervisor's Name & Contact details: Victoria Galbraith (V.Galbraith@wlv.ac.uk) or Abigail Taiwo (bolataiwo31@yahoo.com)
Are you as the Investigator or is your Supervisor a member of the ethics committee?: No

Title of the Research:
Please indicate the type of submission (See Section 3 for Guidance):

- ☐ Category 0 Undergraduate project self-certification
- ☐ Category 0 Other
- ☒ Category A
- ☐ Category B

Please indicate whether the study is:

- ☐ Staff Research (Externally funded)
- ☐ Staff Research (University funded)
- ☒ Postgraduate student Project
  Programme of study:
- ☐ Undergraduate student project - Programme of study:
  Programme of study:

How many words is your proposal: 1,462

Key Words: Countertransference, therapy outcome, therapeutic relationship, management

Please LIST below the major ethical issues you have discussed in the attached research protocol.

4.3 Research Protocol (Part C)

Title of the Proposed Research

'EXPLORING AND UNDERSTANDING THE EXPERIENCES OF COUNTER-TRANSFERENCES AS A COUNSELLING PSYCHOLOGIST (BOTH SUBJECTIVE & OBJECTIVE), WITHIN INDIVIDUAL THERAPY & HOW THIS AFFECTS THE COUNSELLING PROCESS'

Theoretical & Literature Based Background to the Study

As noted by Cartwright (2011)

> *In terms of future directions, it is important that researchers continue to examine the validity and usefulness of the concept of countertransference and its application to practice. It would also be useful to have longitudinal studies that examine psychologists/ methods of managing their countertransference responses, both subjective and objective, and the impact on their therapeutic relationships with clients.* (p53)

Nonetheless Dahl *et al* (2012) has implicated "more research is needed to identify specific linkages between outcome and attentions to [cognitive Therapy] (CT) feelings" (p 23) As well as

"*Future research should look at how transference and countertransference relate to each other and the process of therapy over time with multiple sessions per treatment phase and how the relationship between transference, countertransference, and session quality relate to therapy outcome."* (Markin, McCarthy, & Barber, 2012; p 14)

Rationale & Research Question/Aims/Hypotheses

- **Rationale**

Countertransference research to date in itself is broad with the areas of it being subjective, objective negative, positive, directive, in directive with the effects of therapy outcome, the management of therapy, it has looked at the cognitive aspects, feelings and tested its behaviour (the reactions of countertransference), as well as the ever interplay between transference and countertransference of both the therapist and the client. The problem with this is that these areas have been measured either separately, juxtaposed with two or more areas, but never grouped together simultaneously in a qualitative way. "To clarify the conflicting literature, future research should examine countertransference feelings and countertransference behaviours separately and types (i.e., positive versus negative) of transference and countertransference separately." (Markin, McCarthy, & Barber, 2012;p 12).

Furthermore Ivey (2013) states that, "Increasingly, cognitive therapy (CT) authors are paying attention to understanding and managing countertransference reactions." (p 230) Whereas "Readers following psychotherapy trends may have noticed an increasing number of cognitive therapy (CT) authors writing about countertransference and its relevance to their work" (Ivey,2013;p 231) not to mention others such as Psychodynamic therapists. However this study is aiming to understand countertransference specifically from Practitioners who are Counselling Psychologists; as there seems to be limited research shedding light on this specific population, their objectivity and reflective practice of work. One seeks to fill the gaps in literature by researching internal feelings of countertransference in a detailed manner by focusing on the following:

(ii) Aims: The effects of subjective and objective, positive or negative countertransference (directive or in-directive) within individual therapy, the therapist' management of this entanglement in the moment of experiencing it (whether this be automatic thoughts, feelings or behaviours presented), as well as seeing what type of impact (positive or negative) this may have both on the therapeutic relationship and the outcome of therapy from the therapists perspective. Indeed it is understood that transference is an important part of countertransference as transference affects both participants in the therapeutic setting, but the relevance of this study is primarily to solely capture the nature of the Therapists' inner experience, their world and what this means for them rather than the patient/client.

(i)Research Question: How does subjective and objective countertransference become manageable in the moment of experiencing it and how does this impact upon the development/maintenance of the therapeutic relationship for counselling psychologists?

(iii)Hypotheses: This research thus hopes to investigate and make sense of the complexities of countertransference (objective, subjective, positive, negative etc.) having direct impact not only on the (1) therapist, (2) the therapeutic relationship, but also the (3) outcome of therapy.

Research Design/Approach

The Research design and methodological approach that will be used is going to be a Qualitative study using IPA. Therefore
"the aim of IPA is to explore in detail individual personal and lived experience and to examine how participants are making sense of their personal and social world…IPA has a theoretical commitment to the person as a cognitive, linguistic, affective and physical being…" (Lyons & Coyle 2007, p. 35/6).
Not to mention "IPA studies are conducted with relatively small sample sizes. The priority is to do justice to each case and the detailed case-by-case analysis of individual transcripts." (Lyons & Coyle 2007, p. 39)

Recruitment, Sampling & Study Participants

The target population of the study is Counselling Psychologists' within the UK. From this population both qualified Practitioners and Trainees will be selected due to snowball sampling; by circulated advertisement-'letter to participants'. It is hoped that 6-8 participants will be recruited into this qualitative investigation.

Materials/Data Collection Method(s)

Face to face semi-structured questions within the interview will be used as well as an audio tape recorder for transcription.

Data Collection Procedure

Stage 1: Advertise recruitment poster-'letter to participants' (via email) to existing trainees/registered practitioners who will thus proceed to snowball sampling.
Stage 2: Those interested will be narrowed down, selected and contact will be made to sit and discuss the study e.g. information sheet
Stage 3: Once collaborative agreement to par take in the study has taken place selective interview dates with available and confidential space/setting will be put in place suiting both parties.
Stage 4: on agreed location & time a General Consent form and the right to withdraw will be issued
Stage 5: after collection of data a debrief will be exercised

Data Analysis

The interviews will be analysed by using thematic analysis, where by
The first stage …involves the reading and re-reading of the text…that reflect [the researchers] initial thoughts and observations…to the text. The second stage…requires the researcher to identify and label themes that characterize each section of the text. The third stage involves an attempt to introduce structure into the analysis. The researcher lists the themes identified in stage two and thinks about them in relation to one another. Some of the themes will form natural clusters of concepts that share

meanings or references, whereas others will be categorized by hierarchal relationships with one another. The fourth stage of analysis involves the production of a summary table of the structured themes, together with quotations that illustrate each theme. The summary table should only include those themes that capture something about the quality of the participant's experience of the phenomenon under investigation. (Willig, 2009; p58)

Ethical consideration

Participants will be given consent forms to sign regarding the aims of the study, the research procedure, the expectations required of the participants, confidentiality, information about what will be done with the data gathered and the potential risk (although minimal) that the participants may entail. This is to consider that intentional deception will not take place, participants are well informed and that they have the right to withdraw before, during or up until the commencement of the data analysis. This is to respect the individual, their confidentiality, autonomy and social responsibility.

Debriefing will be done to identify and detect if there were any discomfort or harm throughout the interview. If so taking the necessary assistance and precautions to aid the participants will be implemented. Whether this is signposting to additional services e.g. therapeutic outlets or talking through the experience with the participant**.**

Participants may want to receive a lay summary of the main findings and thus this option will be provided and discussed. Equally their gathered sensitive data will be safe by it being secured and locked away at all times, or that tape/ notes will be stored as long as one needs' to get the data published. Nonetheless it may also be fully destroyed after the completion of the study (for protective and confidentiality reasons) as well as additionally omitting information (replacing their names with letters for anonymity) from the write up that would compromise their identity in any way, this will also be highlighted and deliberated.

Potential problems

Potential problems that may occur can range from everyday circumstances such as participants or researcher not attending scheduled interview meetings due to sickness, accidents or rescheduling. There may not be enough recruited participants or participants may want to withdraw; interviews may be badly recorded or not recorded at all thus delaying capturing/analysing the data.

Pilot study

Two pilot tests will be done and conducted following steps in the 'data collection procedure'. This is to examine whether subjects understand the instructions given e.g. the information sheet (if too much information has been given or not enough), if the questions being asked is comprehensible or need tweaking, also to ascertain how much time it takes to test each subject. No to mention giving me (the researcher) a clear guidance and understanding on what to do, how to do it, examine potential problems and revise the structure to make this a great investigative proces

Appendix 2

School of Applied Science (SAS) Student Management Board

From: Kaur, Ramanjit
Sent: 22 July 2013 14:36
To: Galbraith, Victoria; Joseph, Drusilla
Subject: Research Proposal - Drusilla Joseph

University of Wolverhampton **INTERNAL MEMORANDUM**

School of Applied Sciences **Extn: 1129** **MA135**

City Campus **Email : R.Kaur@wlv.ac.uk**

To : Dr V Galbraith & D Joseph

From: Raman Kaur, Research Administrator

Date: 22nd July 2013

Notification of decision of the SAS/RIHS Student Management Board held on 16th July 2013

Research Proposal

Student: Drusilla Joseph

I am pleased to advise you that the above research proposal was approved.

Appendix 3:

Re-submission and Boards Approval

Dear Sir or Madam:

Re: Resubmitting Ethical Approval Document

Identification of code allocated is: **Pass**

The concerns previously raised were taking into consideration and have been thus approved by the ethics committee whereby I Drusilla Joseph has started to collect data.

However due to the concerns raised as indicated below; one would like to expand the request in contacting participants. One has thus far approached a plethora of Academic institutions such as Bristol UWE, City Univeristy, Manchester, UEL, have advertised on the Division of Counselling Psychology Discussion forum on the BPS, both Facebook in the Division of Counselling Psychology NW Branch and also there newsletter bulletins and e-news flash weekly. As well as snow ball sampling and emailing practitioners from the Counselling Directory on the BPS.

Therefore I have highlighted in red further amendments to increase likely hood of homogeneity; which I would like to open the forum to Counselling Psychology trainees within this institution (Wolverhampton University) but also Clinical trainees.

4) Explain how the supervisors and participants be contacted

I have revised a number of ways to gain contact; not just snow ball sampling.

Yours faithfully,

Miss D. Joseph

Appendix 4:

Behavioural Sciences Ethics Committee (BSEC) approval

Date 7th January 2014

Drusilla Joseph
Flat 2,
182 Leander Road,
Brixton Hill
London

Dear Drusilla

Re: 'EXPLORING AND UNDERSTANDING THE EXPERIENCES OF COUNTER-TRANSFERENCES AS A COUNSELLING PSYCHOLOGIST (BOTH SUBJECTIVE & OBJECTIVE), WITHIN INDIVIDUAL THERAPY & HOW THIS AFFECTS THE COUNSELLING PROCESS'

On review your Resubmitted Research Proposal was passed and given full approval (**Code 1 - Pass**). You are free to continue with your study. We would like to wish you every success with the project.

Yours sincerely

H Paniagua
Dr. H. Paniagua PhD, MSc, BSc (Hons) Cert. Ed. RN RM
Chair – School Ethics Committee

D Chadwick
Dr. D. Chadwick PhD, MSc, BA (Hons). PGCE
Chair – School Ethics Committee

Appendix 5:

Interview Schedule

Questions to Ask for Thesis

Rules:
The risks of this study are minimal, but if you feel the research may have an adverse impact as it may conjure up many emotions, we can stop at any time, alternatively we can sign post you to a Personal Therapist if need be.

Warm up Questions:
1. Where is it that you currently work?
2. Is there a specific theoretical orientation commonly used within that setting?
   (i) If so, do you like using that specific orientation?
   (ii) If not, why not and which do you prefer using?
3. Do you think working in your current setting makes a difference to the way you experience countertransference?
4. How many years have you been practicing therapy?
5. Can you tell me what the word countertransference means to you?

Scenario
I would like you to imagine a previous one to one session that you have conducted by yourself with one individual. This individual is a past client where you no longer work with them therapeutically. With this particular individual reflecting back, I would like you to pick one moment throughout any of your sessions where you experienced countertransference. As you hold that thought I'd like to capture it like a snapshot or photograph, where all of my following questions will be based on. Once you have something we can begin.

Main Questions:

1. Could you describe what was going on for you emotionally?
Possible prompts- was this subjective or objective?

2. Can you talk me through the process of what you were thinking in that moment or what was going on for you cognitively?
Possible prompts - what was your thinking that was attached to your countertransference do you think?

3. How do you think you behaved and were there any physiological signs or symptoms occurring?
Possible prompts - gestalt

4. With this going on for you simultaneously, how did you also focus or re-focus on your clients' needs in that moment or shift?

5. We know countertransference can come in all forms e.g. positive/negative/directive/subjective /objective or a mixture. In that experience or moment how would you describe that particular countertransference and what made it so?

6. Do you think countertransference played a hand at or impacted the outcome of that particular session? (If so why? /If not why not?)

7. How do you think this particular experience of countertransference may have had a direct impact (if any) on the development or maintenance of the therapeutic relationship?

8. What do you think the key main elements are to managing countertransference?
Possible prompts -what about when you experience it in the moment? Any techniques?

9. How do you feel the level of training/skills acquired thus far has helped your approach of managing countertransference?

Extra questions:
10. Do you think countertransference is damaging or encouraging in anyway?

Appendix 6:

Recruitment Advert

ARE YOU A COUNSELLING PSYCHOLOGIST?

If the answer is yes then I would like to invite you to participate in a research project, which I am conducting as part of my Professional Doctorate in Counselling Psychology at the University of Wolverhampton.

I am only in need of Counselling Psychologists' to take part in my research project. The benefits of taking part stands at getting the opportunity to participate in an informative piece of research which will enable the development of therapeutic training and practice, particularly in relation to countertransference.

The aims of this study are to recruit Counselling Psychologists who have experienced countertransference in their therapeutic work. We aim to investigate ways in which countertransference may affect these therapeutic practitioners in the moment of experiencing it and what type of impact this may have on the therapeutic relationship, process, management and outcome of therapy. By conducting this study we hope to gain a better understanding of countertransference and the personal experiences of the Counselling Psychologists involved.

This research will last approximately one hour and there is no need to travel to me as I will travel to you. I shall be interviewing you in a semi-structured way, and will be audio recorded. This will take place at your convenience and all participation is both confidential and voluntary. The data will be analysed using interpretative phenomenological analysis (IPA).

If you feel that you would like to be interviewed please indicate so by contacting me via email where by an information sheet will be provided explaining the title and aims of the project and offers further information on participants' involvement in the process.
D.Joseph@wlv.ac.uk

Yours Sincerely,

Miss Dru Joseph
Counselling Psychologist in Training

Appendix 7:

Information Sheet

UNIVERSITY OF WOLVERHAMPTON
KNOWLEDGE ▪ INNOVATION ▪ ENTERPRISE

Participant Information sheet:

As part of my post-graduate training and my doctoral research at the University of Wolverhampton, I will be conducting a study based on countertransference. Hence the purpose of this letter is to provide you with the information necessary for you to make an informed decision as to whether you would like to participate in this study. Please take your time in reading the information below and ask if there is anything that is not clear. If you feel you need more information, please do not hesitate to contact me at D.Joseph@wlv.ac.uk

Thank you for reading this.

What is the Study about?

Specifically the study looks at the effects of countertransference with all its' complexities; whether this be subjective, objective directive or in directive, positive or negative within individual therapy. As well as the therapists' management of this entanglement of emotions in the moment of experiencing it not to mention what type of impact (positive or negative) this may have both on the therapeutic relationship, session outcome and the overall outcome of therapy from the therapists perspective.

Why am I conducting this Study?

The relevance therefore of this study is primarily to capture the nature of the Therapist's role specifically from Practitioners who are Counselling Psychologists. Therefore to conduct such an investigation the research design and methodological approach that will be used is going to be a Qualitative study using IPA (Interpretative Phenomenological Analysis). This is due to gaining an insight or snapshot into your (the participant's) detailed account of making sense of your own personal perceptions and in particular your experiences of countertransference.

In this case the project title is called **'Exploring and understanding the experience of Countertransference as a Counselling Psychologist (both subjective and**

objective), within individual therapy & how this affects the Counselling process.'

What does the Study involve?

Thus the measures that will be taken in order for this data to be collected will be due to you the participant being involved in a one hour semi structured interview with a number of open-ended questions, using a Dictaphone for transcription. This recorded information will then be analysed using IPA. The only persons who will have access to the raw data will be the interviewer (me) and the research supervisors and examiners. The raw data will be kept for up to five years after the completion of the study and it will be stored securely. In the report and in any publication that results from the research, identifiable information will be anonymised. Additionally you may want to receive a summary of the main findings and you will be provided with my email address should this be the case.

The place of the interview will be established by common agreement (between interviewer and participant).

Anything that you say to the researcher will be kept confidential, unless a disclosure of harm to yourself or to anyone else is made.

You must be aware of the fact that no remuneration will be made for this interview.

You are not obliged to take part at this interview and you are free to withdraw at any time during it; should you choose to withdraw from the interview, you may do so, without disadvantages to yourself and without any obligation to give a reason.

However you can only withdraw your data up until the commencement of the data analysis (07/2014).

The risks of this study are minimal, but if you feel the research may have an adverse impact signposting to external institutions will be advised during debriefing.

This study has been reviewed by the University of Wolverhampton's Research Ethics Committee and adheres to the guidelines within the British Psychological Society's Code of Conduct. Should any matters not be satisfactorily resolved between you (the participant) and me (the investigator); please feel free to contact the supervisory team:

Victoria Galbraith (V.Galbraith@wlv.ac.uk) or Abigail Taiwo (bolataiwo31@yahoo.com)

Thank you for taking part in this study.

Miss Dru Joseph
Counselling Psychologist in Training

Appendix 8:

Consent Form

Miss D. A. Joseph

UNIVERSITY OF WOLVERHAMPTON
KNOWLEDGE ▪ INNOVATION ▪ ENTERPRISE

CONSENT FORM

I have read the information leaflet relating to the interview I have been asked to take part in and I have been given a copy of it to keep.

Yes ☐	*No* ☐

The nature and objectives of the interview have been explained to me, and I have had the chance to discuss the details and ask questions about it.

Yes ☐	*No* ☐

I understand what is proposed and the procedures in which I will be involved have been explained to me.

Yes ☐	*No* ☐

I understand that anything that I say to the researcher will be kept confidential, unless a disclosure of harm to you or to anyone else is made.

Yes ☐	*No* ☐

I understand that my involvement in this study, along with particular data from this interview will remain strictly confidential and that any identifying details will be anonymised. Only the research supervisors, examiners and I will have access to the raw data.

Yes ☐	*No* ☐

It has been explained to me what will happen to the data once the interview/project has been completed.

Yes ☐	*No* ☐

Having given this consent I understand that I have the right to withdraw from the interview at any time during the interview stage without disadvantage to myself and without being obliged to give reason.

Yes ☐	*No* ☐

However I can only withdraw my data up until the commencement of the data analysis (07/2014).

Yes ☐	*No* ☐

I hereby fully and freely consent to participate in the interview.

……..	……..	…….
Name of person taking Consent	Date	Signature
……..	……..	…….
Researcher	Date	Signature

Appendix 9:

Debrief Form

DEBRIEF SHEET

'Exploring and understanding the experience of Countertransference as a Counselling Psychologist (both subjective and objective), within individual therapy & how this affects the Counselling process.'

Thank you for taking part in this study: As noted by Cartwright (2011)
In terms of future directions, it is important that researchers continue to examine the validity and usefulness of the concept of countertransference and its application to practice (p 53), that nonetheless Dahl *et al* (2012) points out that "more research is needed to identify specific linkages between outcome and attentions to (CT) feelings" (p 23). And that "*Future research should look at how… countertransference relates to… session quality [and] therapy outcome (*Markin, McCarthy, & Barber, 2012; p 14*).*
As you are aware, this study is concerned with Countertransference, If you would like any further information about the study or to be provided with the results of the study, please do not hesitate to contact me on D.Joseph@wlv.ac.uk

Questions:

1. How did you find that?
2. Is their anything you did not understand or would like to reflect over?
3. Do you have any questions?

If answering any of these questions led you to feel distressed and you would like to speak to someone about your thoughts please contact the following:

Signposting Institutions or Organisations:

Personal Therapy- www.bacp.co.uk
Finding a Psychologist- www.bps.org.uk

Additionally if you are interested in the current literature and research and may wish to read around this topic references are listed below.

References if interested:
Cartwright, C., & Read, J. (2011). An Exploratory Investigation of Psychologists' Responses to a Method for Considering "Objective" Countertransference. *New Zealand Journal of Psychology, 40* (1), 46-54.

Dahl, H., Rossberg, J., Bogwald, K., Gabbard, G., & Hoglend, P. (2012). Countertransference feelings in one year of individual therapy: An evaluation of the factor structure in the feeling word checklist-58*. Psychotherapy Research, 22*(1), 12-25.

Markin, R., McCarthy, K., & Barber, J. (2012). Transference, countertransference, emotional expression, and session quality over the course of supportive expressive therapy: The raters' perspective. *Psychotherapy Research, 117*

Appendix 10:

Table of themes-connections subjectively and objectively

1. Looking for connections subjectively and objectively

Subjective Countertransference	***Objective Countertransference***	***Contributing Factors to Countertransference***
Introspection Stuck with Cognition Recognition of containment Internal pressures Integrated style Awareness & acknowledgment Paying attention to parts of the self Worried to burden Client Acceptance Awareness Insight into Managing CT Intra psychic connection Interpret through necessary awareness Awareness of projection identification *Barriers/ boundaries* Separate Feelings Separate Cognitions Holding back Competent Battle of integrative/interventions Self-preservation Holding power in therapeutic relationship Think before reacting Solution focused Have a sequence to work by Professionalism versus immediacy Self talk Grounding techniques Stuck Feeling	Projection Projection Identification Good enough Mother role Reflexivity Client focused Played victim Paying attention Awareness of client Readiness of Client Participant resistance Defensive walls Addressing the issues Containing the response Simultaneous response Oedipus Complex empathy Taking transference personal Interconnectedness Keeping a professional identity Responsibility of client Passing back power to client Emotional entanglement Familiarity Limitations of Service Pressure from service Seven Eye Model Restrictions of service Drained from the service Pressure to fix Less freedom Solution focused Differences In services	Limitations of Service Pressure from service Seven Eye Model Restrictions of service Drained from the service Pressure to fix Less freedom Solution focused Differences In services (NHS V Private/independent) Limitations of Sessions Awareness of sector/service demand Controlled by Service (direction & pace of therapy) Gender awareness within service- power dynamics Management (power games) NHS demands Timing Relational depth Trust issues Malan's Triangle (judging/persecutory roles)

Reassurance of self Checking in Guarded (no self-disclosure) Using space for own needs Aware of coping strategies Self management Shifting positions Alienates skills Security not offered Difficulty with congruence Blocked parts of self Self- reflection Self –Awareness Nor feeling "good enough" Doubts Skills Easily swayed internally Unconfident Core beliefs Ontological understanding Unresolved conflicts Congruency Heavy Trauma Gratitude Reflective Emotional entanglement Judgmental Avoiding testing the process Fear of exposure Highlighted emotions Self-sabotaging Self-critical Mixed reactions Body reactions Distracted (mind elsewhere) Selfish Immediacy No ownership Reactory Egotistical	(NHS V Private/independent) Limitations of Sessions Awareness of sector/service demand Controlled by Service (direction & pace of therapy) Gender awareness within service- power dynamics Management (power games) NHS demands	Edge of awareness Building trust Connection Intellectualisation Avoidance Attunement between research therapist and client Comparing lives – dual processing CT as a tool Ct not clear cut, hinders judgment and comes in cycles More Training Paying attention Concrete evidence to get results Boundaries More Techniques Recognition

Appendix 11:

3. Cluster of themes *Subjectively* with ALL participants

1. ***Interpretation through Awareness***
   - Introspection
   - Stuck with Cognition
   - Recognition of containment
   - Internal pressures
   - Integrated style
   - Awareness & acknowledgment
   - Paying attention to parts of the self
   - Worried to burden Client
   - Acceptance
   - Awareness
   - Insight into Managing CT
   - Intra psychic connection
   - Interpret through necessary awareness
   - Awareness of projection identification

2. ***Logistics over feelings***
   - *Barriers/ boundaries*
   - Separate Feelings
   - Separate Cognitions
   - Holding back
   - Competent
   - Battle of integrative/interventions
   - Self-preservation
   - Holding power in therapeutic relationship
   - Think before reacting
   - Solution focused
   - Have a sequence to work by
   - Professionalism versus immediacy

3. ***Techniques***
   - Self talk
   - Grounding techniques
   - Stuck Feeling
   - Reassurance of self
   - Checking in
   - Guarded (no self-disclosure)
   - Using space for own needs
   - Aware of coping strategies
   - Self management

- Shifting positions
4. ***Humanistic*** - Alienates skills - Security not offered - Difficulty with congruence - Blocked parts of self - Self- reflection - Self –Awareness - Nor feeling "good enough" - Doubts Skills - Easily swayed internally - Unconfident - Core beliefs - Ontological understanding - Unresolved conflicts - Congruency - Heavy Trauma - Gratitude - Reflective - Emotional entanglement - Judgmental
1. Immediacy of Self - Avoiding testing the process - Fear of exposure - Highlighted emotions - Self-sabotaging - Self-critical - Mixed reactions - Body reactions - Distracted (mind elsewhere) - Selfish - Immediacy - No ownership - Reactory - Egotistical

Appendix 12:

4. Cluster of themes *Objectivity* with ALL participants

1. Primary level - Projection - Projection Identification - Good enough Mother role - Reflexivity - Client focused - Played victim - Paying attention - Awareness of client - Readiness of Client - Participant resistance - Defensive walls
2. Secondary Level - Addressing the issues - Containing the response - Simultaneous response - Oedipus Complex - Empathy - Taking transference personal - Interconnectedness - Keeping a professional identity - Responsibility of client - Passing back power to client - Emotional entanglement - Familiarity

Appendix 13:

5. Cluster of themes *of Contributing Factors* to CT *with ALL participants*

1. Internal Pressures - Limitations of Service - Pressure from service - Seven Eye Model - Restrictions of service - Drained from the service - Pressure to fix - Less freedom
2. External Pressures - Solution focused - Differences In services (NHS V Private/independent) - Limitations of Sessions - Awareness of sector/service demand - Controlled by Service (direction & pace of therapy) - Gender awareness within service- power dynamics - Management (power games) - NHS demands
3. Readiness for Relational Depth - Timing - Relational depth - Trust issues - Malan's Triangle (judging/persecutory roles) - Edge of awareness - Building trust
4. Debris of CT - Connection - Intellectualisation - Avoidance - Attunement between research therapist and client - Comparing lives – dual processing - CT as a tool - Ct not clear cut, hinders judgment and comes in cycles
5. Preparations - More Training - Paying attention - Concrete evidence to get results - Boundaries - More Techniques - Recognition

Appendix 14:

Preliminary Tables of Super-ordinate and Sub-ordinate themes

6. Sub-ordinate themes:

1. ***Interpretation through Awareness***
2. ***Logistics over feelings***
3. ***Techniques***
4. ***Humanistic Self***
5. ***Immediacy of Self***
6. ***Primary level – of client and what they bring***
7. ***Secondary Level- of the client what the bring but changes the therapist***

Super-ordinate themes (Major Themes):

Professional
Personal
Reactors
Clients life outside the Analysis
Service Restrictions
Therapeutic Relationship
Training

Appendix 15:

Tables of Super-ordinate and Sub-ordinate themes

Subjective' Super-ordinate and Subordinate themes

Super-ordinate	Sub-ordinate themes
Professional	• Interpretation through Awareness • Logistics over feelings • Techniques
Personal	• Humanistic Self
Reactors	• Immediacy of Self

Table 3: 'Objective' Super-ordinate and Subordinate themes

Super-ordinate	Sub-ordinate themes
Clients life outside the Analysis	• Primary level -Projection -Projection Identification -Readiness of Client • Secondary Level - Double subjectivity

Table 4: 'Contributing Factors to Countertransference' Super-ordinate and Subordinate themes

Super-ordinate	Sub-ordinate themes
Service Restrictions	• Internal Pressures • External Pressures
Therapeutic Relationship	• Readiness for Relational Depth • Debris of CT
Training	• Preparations

Appendix 16:

Major Theme Table

A summary table of the structured themes, together with quotations that illustrate each theme

Major Themes	Illustrative Quotes
1. **Professional**	*"…the idea about developing an internal supervisor and being in touch with that… I think in those moments when I'm in that transference and countertransference… I have that…internal check in with my supervisor… quick check in on processing content"*- (*PW*, P5/6, 210-222) *"I felt I had the confidence in that particular session to raise that… I think it was a big decision to do…but I think it needed to happen"(JP, p5, 177-78/187-88)* *"I'll bring in erm different models…to kind of guide me…more or less integrative...depending on what the client needs at the time [are]…"(FF, P1, 8-13)* *"I think I went into solution finding, I wanted to get something concrete that I could give her…(SB, P2, 77-79)*
2. **Personal**	*"…at the time that I was working with that client, I was also having personal therapy and my therapy was psychodynamic therapy…it was interesting how much when we pulled out countertransference… that often I was on a parallel process with my clients…it was unreal really cause their lives are so different…you just didn't realise how so close things were, and then you'd realise how important it is to bracket off your stuff with their" (WF, p6 231-238)* *"I think…for me is to be able to just say did I feel this before I came in and if I did it's probably to do with me and if I didn't*

	chances are its to do with the in between…"(SC, p8, 344-346) *"I got that kind of sense of in a way when she spoke about her pain and her loss I could resonate with 'yes I could hear her pain and her loss', but also I could feel a different part of me which was connected with my pain and my loss."* (*PM*, P3, 118-121)
3. **Reactors**	*"I've come away…feeling so frustrated and thinking 'hang on a minute' this isn't my stuff…(FF, p4 161-162)* "*I just wanted to switch off*" (*JP*, P4, 140) "*there is a natural rescuer part of me"* (*SB*, P3, 92)
4. **Clients life outside the Analysis**	*"…I suppose the main thing was the feeling out of control of the process its almost like erm the control went straight to him and I was kind of panicking cause I'm thinking now 'I need to get some of this back somehow' (FF, P4, 141-144)* *" [I have this client] at the moment who really she just expects me every time despite me being you know wonderful, gentle, kind, caring and compassionate therapist she treats me like I hate her, cause her mum hates her and this is a older person, you know mums dead but she still carries round with her, her mum who hated…"(SC, P10, 425-428)* "[*I had*] *to kind of pull myself back and kind of give her…that space and then I can kind of be here and listen to it, but I'm not gonna jump in and kind of drown*

	with [her]…" (*SB*, P3, 131-133) "…what the client projects onto me perhaps from earlier relationships that they've had as a kind of a young child…" (*PM*, P2, 66-67)
5. **Service Restrictions**	*"I have this kind of external kind of pressure on me which is about targets, performance an seeing people"* (*PM*, P2, 49-50). "*…the NHS…they've got lots of erm rules and regulations that sometimes can leave you feeling erm a bit straint… that influences my work with my clients…"* (*FF*, P1, 23-4/31) "*I think I put pressure on my self to be able to do CBT… especially because of IAPT service its more…structured CBT so kind of agenda setting it really is quite… difficult at times and I think because of the session lengths as well there's only so much you can do, so if you did want to kind of deviate from the plan say, you really need that time to be able to do that*" (*JP,* P1, 17-20) "*…a lot more kind of under pressure within CAMHS… often with parents and social workers…*" (*SB*, P1, 28-32)
6. **Therapeutic Relationship**	"*Client was watching me at this point as well with a with a brief smile…very kind of protective erm and the behaviour er probably quite quiet an just letting the client carry on rather than intervening straight away…"(FF, P5, 192-104)*

	"[What] I might do depends really on the needs of the client and what I felt was going to be helpful and what I feel could be heard cause sometimes you got a countertransference, your aware of transference and countertransference but you might not interpret it back to the client cause there not at a place where they could be ready to hear that much more, to raw, to close, to difficult." (SC, P1, 19-23) , *"...she was then able to trust me so because of that trust and that relationship we built together other things"* (*WF*, P6, 214-215). *"I think...how much is this affecting our process our therapeutic process"* (*JP,* P7 276-277)
7. **Training**	"*I would have love to have gone on to do full training cause psychodynamic is my favourite approach… I think the training that I had and the reading that I've done is sufficient for that" (WF, P7; 278-287)* "*…trying to distinguish whose stuff this is, is this my stuff or there stuff erm an in doing that it was really valuable" (FF, P10, 386-393)* *"…I suppose your training and your reading and all the rest of it makes you aware of it …training and supervision can help you learn to spot it…" (SC, P9 374-380)* *"...I think its erm you get a background a brief background of what it is…"* (*JP*, P 7/8, 303-310)